



**CHRISTUS MOTHER FRANCES HOSPITAL –  
TYLER, LOUIS & PEACHES OWEN HEART  
HOSPITAL & CHRISTUS MOTHER FRANCES  
HOSPITAL OUTPATIENT SURGERY CENTERS  
MEDICAL STAFF  
AMENDED AND RESTATED BYLAWS**

**GOVERNING BOARD APPROVAL MARCH 15, 2013  
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## Definitions

1. *Administrator or Chief Executive Officer* means the individual appointed by the Governing Board to act on its behalf in the overall management of the Hospital.
2. *Affected Practitioner* means a member of the Medical Staff against whom a corrective action has been requested, recommended, or taken.
3. *Advanced Allied Health Professional or Advanced AHP* means a licensed mid-level practitioner who is licensed, registered, certified and/or authorized to provide health care services in the State of Texas by the applicable licensing or accrediting authority and is identified in Appendix A to the Mother Frances Hospital Allied Health Professional Manual. The terms also refer to licensed mid-level practitioners who may or may not be employed by the Hospital or clinic; however, those licensed mid-level practitioners with privileges at the Hospital and its clinics may exercise privileges with a Sponsoring Medical Staff Member with patient co-management responsibilities.
4. *Attending Physician* means the physician of record. The Attending Physician is responsible, within the scope of his/her license and privileges, for the professional quality care and treatment of each patient s/he admits and cares for, holds legal and ethical responsibility for directing care of the patient and ensures the patient's documented visit accurately reflects the care rendered, clinical outcomes and treatment plans.
5. *Bylaws or Medical Staff Bylaws* means the Amended, Restated, and Adopted Medical Staff Bylaws of the Hospital.
6. *Dependent Allied Health Professional or Dependent AHP* is identified in Appendix A to the Mother Frances Hospital Allied Health Professionals Manual. The terms also refer to health care professionals other than physicians and Advanced AHPs who may or may not be employed by the Hospital or clinic and may hold a certificate, license or other authorization under state law. These professionals work under the close supervision of a Sponsoring Medical Staff Member.
7. *Executive Committee or Medical Executive Committee or MEC* means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Board.
8. *Governing Board* means the Governing Board of the Hospital.
9. *Hospital* means Mother Frances Hospital Regional Health Care Center, including the Louis and Peaches Owen Heart Hospital.
10. *Medical Staff or organized Medical Staff* means the group of healthcare professionals who have been granted appointment to the medical staff of the Hospital by the Governing Board in accordance with these Bylaws and have the right to vote on adopting and amending these Bylaws, the Rules and Regulations, and the Hospital policies and procedures related to Medical Staff processes and patient care. The organized Medical Staff is a self-governing entity accountable to the Governing Board.
11. *Professional Member or Licensed Independent Practitioner* means an appropriately

licensed allopathic or osteopathic physician, or an appropriately licensed dentist, or an appropriately licensed podiatrist with current licensure.

### **ARTICLE I: NAME**

The name of this organization shall be the Mother Frances Hospital Medical Staff.

### **ARTICLE II: PURPOSES**

The purposes of this organization are:

1. To provide oversight for a uniform quality of care, treatment and services delivered by the practitioners who are credentialed and privileged through the medical staff process;
2. To set forth the process and criteria for the credentialing, privileging and evaluating the competency of all physicians, licensed independent practitioners and allied health staff;
3. To provide leadership in performance improvement activities, to improve quality of care, treatment and patient safety; and
4. To establish a framework for how the Medical Staff will organize and govern its affairs.

For the purpose of these Bylaws, the medical staff year commences on the first day of January each year.

Under no circumstances should these Bylaws and/or Rules and Regulations be interpreted as the standard of care or as any indicia of standards of care for the members of the Medical Staff in the care and treatment of patients.

### **ARTICLE III: MEDICAL STAFF MEMBERSHIP**

#### **SECTION 1. Nature of Medical Staff Membership**

Membership on the Medical Staff of Mother Frances Hospital is a privilege, which shall be extended only to competent professionals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and Hospital.

#### **SECTION 2. Qualifications for Membership**

- a. Only professionals with a Doctor of Medicine or Doctor of Osteopathy degree, dentists, or podiatrists holding a license to practice in the state of Texas, and who have sufficient postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education, American Osteopathic Association, Bureau of Professional Education, Council on Education of the American Podiatric Medical Association, American Dental Association, and, if applicable, holding a certificate by the Education Council of Foreign Medical Graduates, who can document evidence of the following parameters; current licensure; education and relevant training; and experience, physical ability and current competence to perform the requested privilege and to carry out patient carry activities.

This process will include an assessment for proficiency in the six areas of General Competencies adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative: patient

care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practitioner.

- b. Any applicant for staff membership shall provide current evidence of professional liability insurance and tail coverage. This policy must provide at a minimum an individual policy for the practitioner. The type, amount and duration of coverage shall be determined by the Governing Board upon recommendation of the Medical Executive Committee. If there is a disagreement, the difference shall be decided by a joint committee composed of an equal number of members from the Governing Board and the Medical Executive Committee.
- c. Any applicant for staff membership must have a current and unrestricted license to practice in the State of Texas and, when required by the practitioner's field of practice, unrestricted registration numbers from the U.S. Drug Enforcement Agency ("DEA") and Texas Department of Safety ("DPS").
- d. Applicant for staff membership shall provide a current e-mail address for Medical Staff communication purposes. There is an expectation that the applicant will access their e-mail at least weekly.
- e. Applicants shall not be denied membership and/or clinical privileges on the basis of sex, race, creed, color or national origin, disability, or on the basis of any other criteria, lacking professional justification.
- f. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement to abide by the Principles of Medical Ethics of the American Medical Association, or the American Osteopathic Association Bureau of Professional Education, or by the Code of Ethics of the American Dental Association, or the American Podiatric Medical Association, whichever is applicable, and the Ethical and Religious Directives for Catholic Health Care Services, and the Medical Staff Bylaws, Rules and Regulations as well as any Hospital policies and procedures, all as thereafter amended or updated. A signed Code of Conduct must accompany all initial applications.
- g. Members must report any (i) arrests, (ii) restrictions or reprimands by the Texas Medical Board, (iii) exclusion from any state or federal governmental program, including Medicare/Medicaid or adverse action related to a Member's eligibility to participate in such governmental programs, or (iv) loss or restriction of privileges at any other facility within 30 days of such action.
- h. Any practitioner excluded from the Medicare/Medicaid/Tricare or any government funded health care program will not be offered membership and/or clinical privileges until such sanction is clear.

### **SECTION 3. Conditions and Duration of Appointment**

- a. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, and revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Board may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and

ethical qualifications obtained from reliable sources other than the Medical Staff.

- b. A Focused Professional Practice Evaluation (FPPE) shall be initiated for each initial applicant. Practitioners must comply with and actively participate in FPPE. The evaluation should be completed within 3-6 months of initiation of clinical activity (unless there is insufficient clinical data to assess competency). The department chair/section chief or appointed active staff member will review and approve the completed FPPE. (See FPPE Policy & Procedure)
- c. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Board in accordance with these Bylaws.
- d. Appointment to the Medical Staff shall also confer a requirement for unassigned Emergency Room call coverage. Members of the Active and Courtesy Category shall have an obligation to participate in the unassigned Emergency Room call according to the limitations of his/her clinical competence and privileges unless exempt by virtue of being at least sixty (60) years of age (or an alternative age adopted by their department or section and approved by the Medical Executive Committee), and with a minimum of five (5) years of prior unassigned Emergency Room call and an exemption determined by the Medical Executive Committee. The on-call physician must be able to arrive at the Hospital within thirty (30) minutes of being called which requires residence within a reasonable distance from the Hospital. This requirement is designed to ensure that the Emergency Department has physicians available to meet the needs of patients with emergency medical conditions as well as to meet the needs of those patients without an established physician.
- e. Each applicant shall sign an application for staff appointment, and shall specifically acknowledge the obligation as a staff member to provide continuous care and supervision of patients, to abide by the Medical Staff Bylaws, Rules and Regulations.
- f. Certifications and supporting documentation which relate to the practitioner's specialty must be provided at the time of reappointment. Trauma Surgeons and Medical Staff Trauma Liaisons who participate in trauma call coverage shall be required to maintain sixteen (16) hours per year of trauma-related continuing education as required by the American College of Surgeons. It shall be the responsibility of the staff members to provide certifications and supporting documentation of the required sixteen (16) hours of trauma related continuing education to the Hospital Trauma Program Director on an annual basis. All other staff members shall provide certifications and supporting documentation at the time of reappointment or annually as required by accreditation / certification programs or as specified on clinical privilege delineation forms as approved by the section or department. Failure to provide certifications and supporting documentation of continuing medical education shall result in disciplinary action up to and including loss of staff membership and privileges.

#### **SECTION 4. History and Physical**

Each practitioner with privileges shall prepare and complete in timely fashion, according to medical staff and Hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, clinical services or departments.

- a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, (an oral and maxillofacial surgeon, dentist, podiatrist), or other qualified licensed individual in accordance with State law and Hospital policy.
- b. An updated examination of the patient, including any changes in the patient's condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, (an oral and maxillofacial surgeon, dentist, podiatrist), or other qualified licensed individual in accordance with State law and Hospital policy.
- c. The content of complete and focused history and physical examinations is delineated in the rules and regulations.

#### **SECTION 5. Notice of Adverse Actions and Changes in Liability Insurance**

Members must provide immediate notice to the President of the Medical Staff and the Hospital Administrator of the following: (a) change in or loss of professional liability insurance coverage; (b) an adverse license action in any jurisdiction; (c) adverse credentialing action at any hospital that is reportable to the National Practitioner Databank; (d) exclusion from the Medicare, Medicaid, TRICARE, or any state or federal government funded health care program; (e) conviction of a felony; (f) the filing or service of any professional liability demand letter or lawsuit; (g) the settlement of or judgment in any malpractice action, regardless of the amount; (h) voluntary surrender of privileges with any health care facility; (i) the entry of an order with any licensing board whether public, non-public, voluntary, agreed, disciplinary or non-disciplinary; (j) the initiation of formal action against the practitioner relating to the treatment of a patient, professional conduct, or professional competence of the practitioner by any professional licensing board, the DEA, the U.S. Food and Drug Administration, Medicare, Medicaid, TRICARE, any state or federal government funded health care program or any health care facility other than the Hospital for matters relating to the practitioner's professional competence, professional conduct or billing practices.

#### **SECTION 6. Leave of Absence**

A leave of absence may be granted for not more than one (1) year with the staff member retaining current staff status. Leave of absence must be requested in writing with the staff member stating specific reason(s), the beginning date, and the requested duration. Prior to returning from an approved leave of absence it is the responsibility of the staff member to submit a letter confirming completion of the leave of absence. In case of leave of absence of more than one (1) year, the staff member must reapply for medical staff membership.

In circumstances when the leave of absence is due to illness, incapacity, or impairment or other causes that could affect the practitioner's ability to fully and competently exercise the scope of practice or scope of service granted, reinstatement is conditioned upon a showing that:

- (a) The practitioner has submitted to the Credentials Committee a written request for

reinstatement at least 30 days prior to the expiration of the leave, and demonstrated that the reasons for the leave will no longer exist by the expiration of the leave or by the requested date for reinstatement;

- (b) In case of impairment, the practitioner must present a letter of release from the his/her personal physician, and, as may be required by the Medical Executive Committee, an agreement for ongoing treatment or therapy, a treatment plan from a treating physician, and the practitioner's agreement for random testing, if applicable;
- (c) The practitioner currently meets all of the qualifications for membership set forth in these Bylaws; and
- (d) The practitioner has submitted such other information as requested by the Credentials Committee, the MEC, or the Governing Board.

No reinstatement of a leave granted under (b) above shall be effective until approved by the Governing Board upon the recommendation of the MEC.

## **SECTION 7. Resignation**

It is the responsibility of any Medical Staff member to submit a letter of resignation when resigning from the Medical Staff.

## **ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF**

### **SECTION 1. The Medical Staff**

The Medical Staff shall be divided into Active (also includes Administrative & Continuity of Care), Courtesy (includes Locum Tenens & Honorary) and Affiliated Categories.

### **SECTION 2. The Active Category Medical Staff**

The Active Category Medical Staff shall consist of practitioners who regularly admit patients, provide consultations, and/or use Hospital facilities to perform procedures and deliver patient care according to the limitations of his/her clinical competence and privileges. Additionally, all provider-based Trinity Clinic physicians shall belong to this category although they may choose to delegate in-patient responsibilities to the physician of their choice who has Active membership and appropriate privileges.

The Active Category Medical Staff shall

- Meet the qualifications of membership, in accordance with Article III, Section 2
- Be eligible to vote on adopting and amending Medical Staff Bylaws
- Assume responsibility for governance of the Medical Staff in accordance with these Bylaws
- Perform oversight activities of the organized Medical Staff
- Practice only within the scope of their privileges granted by the governing board
- Provide leadership in activities related to patient safety
- Provides oversight in the process of analyzing and improving patient satisfaction
- Participate in performance improvement activities, clinical programs, and Hospital operational projects and provide medical expertise and direction in such activities as appropriate
- Be eligible to hold office

- Be located closely enough to the Hospital to provide continuous call coverage to their patients; and, if part of a call group must specify the call group and provide written acknowledgement from the group.

Administrative Membership:

- Practitioners in an administrative role within the Hospital and Clinics may choose this division
- These exempt physicians include the Chief Medical Officer of Trinity Mother Frances Hospitals and Clinics, and the Senior Vice-President of Medical Staff Affairs of Mother Frances Hospital or its or their equivalent
- Shall be exempt from the unassigned Emergency Department call
- Practitioner shall have no direct responsibility for the care of patients in the Hospital or Clinics and shall have no consultation or procedural privileges
- May not vote
- May not hold office

Continuity of Care Membership

- Practitioners who regularly refer patients to the Hospital for admission or testing and who may wish to follow the progress of their patient while hospitalized.
- Practitioner shall have no direct responsibility for the care of their patients in the Hospital and shall have no consultation or procedural privileges
- Shall provide continuous call coverage for their patients by specifying which call group will provide coverage as well as provide written acknowledgement from the group prior to being appointed to the Medical Staff
- Each member shall have an obligation to participate in the unassigned Emergency Department call according to the limitations of his/her clinical competence and privileges unless exempt by their department or section, and with a minimum of five (5) years of prior unassigned Emergency Department call and approval by the Medical Executive Committee. Since membership in this category is limited to continuity of care only, the obligation for unassigned Emergency Department call must be assumed by a member of the Medical Staff with Active Category Medical Staff membership and privileges
- May not hold office
- May not vote

**SECTION 3. The Courtesy Category Medical Staff**

The Courtesy Category Medical Staff shall consist of those members who shall be privileged to admit and/or consult. Examples of Courtesy Category Medical Staff are:

- Reasons of health
- Duty with the armed forces
- Extenuating circumstances approved by the Medical Executive Committee

Courtesy Category membership and privileges are defined as being:

- Time-limited as defined by the Medical Executive Committee
- Procedure specific to meet a specific patient care need with a defined limit on patient encounters

- Each procedure request shall be reviewed by the department and/or section and forwarded to the Medical Executive Committee for action
- Shall provide continuous coverage for the patient during their hospitalization; or in the alternative shall specify the name of the practitioner with comparable privileges who will cover call
- May not hold office
- May not vote
- Such limitations shall be considered non-reportable as recommended by the Credentials Committee and subject to approval by the Medical Executive Committee

The Courtesy Category will also include the following:

Locum Tenens Membership:

- A practitioner specifically designated and sponsored by a current staff member to attend a member's patients during the absence of the member
- A practitioner brought in when there are insufficient physicians in an area of practice. Practitioner shall attend only the patients of the sponsoring staff member, and only during the absence of such member
- A practitioner brought in to perform a procedure no other practitioners perform due to patient care need
- Practitioner shall have the obligation for emergency department call coverage for the current staff member they are covering according to the extent of their clinical competence and privileges
- Membership and privileges are termed when the need no longer exist
- Shall be reappointed annually
- May not vote
- May not hold office

Honorary Medical Staff Membership:

- Status designed to provide recognition for practitioners who have made significant contributions to the practice of medicine, community health or to the field of healthcare
- Members in this category must be nominated by the Credentials Committee or Medical Executive Committee
- No privileges or call responsibility
- May not vote
- May not hold office
- No reappointment requirement
- Lifetime appointment unless removed by the Governing Board

Members of the Courtesy Category Medical Staff shall not be required to participate in Medical Staff meetings. Members of the Courtesy Medical Staff shall be requested to provide proof of proficiency and competence to maintain their privileges at the time of reappointment.

**SECTION 4. The Affiliated Category Medical Staff**

The Affiliated Category Medical Staff shall consist of physicians, dentists and podiatrists who are not eligible for appointment to the Active or Courtesy Category. The Affiliated Category shall consist of physicians, dentists or podiatrists whose clinical privileges shall be exercised only within the non-provider based Trinity Mother Frances Clinics. The applicant for Affiliated Staff Category

membership shall meet the qualifications and adhere to the conditions and duration for staff as defined in Article III, Section 2. Appointees to the Affiliated Category shall have no Hospital admitting privileges, staff committee responsibilities, may not vote and may not hold office. They are encouraged to attend section meetings.

**ARTICLE V: PROCEDURE FOR APPOINTMENT,  
PROMOTION AND REAPPOINTMENT**

**SECTION 1. Application for Appointment**

- a. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board after appraisal by the department chair or section chief of the applicable service, recommendation by the Credentials Committee and consultation with the Medical Executive Committee. The initial applicant shall submit the completed and signed application on the prescribed form with a non-refundable application fee as specified by the Hospital.
- b. All applications shall require the following detailed information concerning the applicant's professional qualifications:
  - 1. The name of at least three (3) peers in the same professional discipline as the applicant who have had extensive experience in observing and working with the applicant who can provide adequate references pertaining to the applicant's professional competence and ethical character. One of the 3 references should be the residency or fellowship program director for applicants recently completing training or, the Chief of Service from a hospital affiliation where the applicant is currently clinically active. Only one of the three peer references can be a partner.
  - 2. Evidence of current state license, DEA and DPS certificate (if applicable);
  - 3. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution, whether voluntarily or involuntarily; and whether any such action is currently pending;
  - 4. Information as to whether the applicant's membership in local, state or national medical societies, or license to practice in any profession in any jurisdiction, has ever been suspended or terminated, whether voluntarily or involuntarily; whether any such action is currently pending; including any Agreed Orders with state medical boards or medical societies;
  - 5. Information as to whether the applicant has ever been convicted of a felony and whether the applicant's narcotic license has ever been suspended or revoked, whether voluntarily or involuntarily; and, whether any such action is currently pending;
  - 6. Previously successful or currently pending challenges to any licensure or registration in any state and in any healthcare related profession (Federal/CMS, State, Drug Enforcement Administration, and DPS);
  - 7. Relevant practitioner-specific data as compared to aggregate data, when available;

8. Ongoing Professional Practice Evaluation (OPPE) data, when available;
9. Evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;
10. Current evidence of adequate professional liability insurance in the type, amount and duration prescribed by the Governing Board. This policy must provide at a minimum an individual insurance policy for the practitioner physician;
11. Confirmation of the absence of any physical or mental condition which could affect the applicant's ability to exercise the clinical privileges requested safely and competently (regardless of how this is answered, the application will be processed in the usual manner). This documentation shall be confirmed;
12. Practitioners with inpatient privileges are required to take unassigned emergency room call and must reside within a reasonable distance of the Hospital or delegate in writing these responsibilities to another member of the medical staff;
13. A request for specific clinical privileges desired by the applicant;
14. A portion of continuing medical education hours should relate in part to the practitioner's specialty. Continuing medical education certifications and supporting documentation relating to the practitioner's specialty must be provided at the time of reappointment or annually as required by accreditation / certification programs or as specified on clinical privilege delineation forms as approved by the section or department. Trauma Surgeons and the Medical Staff Trauma Liaisons who participate in trauma call shall be required to maintain sixteen (16) hours per year of trauma-related continuing education as required by the American College of Surgeons Committee on Trauma. It shall be the responsibility of the staff member to provide certifications and supporting documentation of the required hours of trauma related continuing education to the Hospital on an annual basis. Failure to provide certifications and supporting documentation of continuing medical education shall result in disciplinary action up to and including loss of staff membership and privileges.
15. Evidence of completion of EHR training by TMFHS ConnectCARE trainer.
16. A statement indicating that he/she has received, read, and agrees to abide by these Bylaws, the Rules and Regulations, Hospital policies and procedures, and other governing documents of the Medical Staff and the Hospital, applicable to the Medical Staff members made available to him/her.
17. A grant of absolute immunity to and a release of the Hospital, the governing board, the Medical Staff, all peer review and medical committees, including, but not limited to the Credentialing Committee, and their members, the Hospital and Medical Staff officers and authorized representatives, and any third parties from any and all liability for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving the practitioner that are performed, made, requested, or received by such persons without malice related to the following:

- a. Applications for appointment, reappointment, or clinical privileges, including temporary clinical privileges;
- b. Periodic reappraisals undertaken for reappointment or for an increase or decrease in clinical privileges;
- c. Proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary sanction;
- d. Summary suspension;
- e. Hearings and appellate reviews;
- f. Medical Care evaluations;
- g. Utilization reviews;
- h. Any other Hospital, Medical Staff, Department, Division, or committee activities;
- i. Matters or inquiries concerning the practitioner's professional qualifications, credentials, clinical competence, character, ethics, behavior, or ability to perform fully the essential functions of the professional services and clinical privileges requested; and
- j. Any other matter that might directly or indirectly have an effect on the practitioner's competence, patient care, or the orderly operation of the Hospital or any other hospital or health care facility.

The practitioner acknowledges that all proceedings or information relating to the above shall be privileged to the fullest extent permitted by law and that the privilege extends to the Hospital, the governing board, the Medical Staff, all peer review committees, including, but not limited to the Credentialing Committee, and their members, the Hospital and Medical Staff officers and their authorized representatives, and any third parties who provided information or participated in the proceedings.

- c. The completed application shall be submitted to the Medical Staff Central Credentialing Office. Once the Medical Staff Office has collected and verified the references and other materials deemed pertinent, the completed application and all supporting materials shall be submitted to the applicable Section Chief or Department Chair for review, and then to the Credentials Committee chairperson for evaluation. Primary source verifications are listed below, but may not be inclusive:
  - 1. Current licensure, registration and/or certification. Document and verify from primary sources the Practitioner's current licensure, registration and/or certification status.
  - 2. Relevant education, training and experience. Document and verify from primary sources whenever feasible the veracity of the Practitioner's disclosures regarding relevant education, training and experience; and query the National Practitioner Data Bank.
  - 3. Continuing professional competence. Review of at least three (3) written references from individuals in the same or similar professional discipline as the Practitioner and who are knowledgeable about the Practitioner's professional performance within the past two (2) years to attest to and confirm the Practitioner's continuing professional competence and ability to perform the privileges requested. Additional references may include peers who are neither related to nor associated in practice with the Practitioner, but who are personally acquainted with the Practitioner's professional qualifications and current professional competence.

4. Health status. Confirm absence of any substance abuse or health conditions that may adversely affect the Practitioner's ability to perform the privileges or scope of service requested from the chief of service or staff at another hospital where the Practitioner has privileges or scope of service, or by a currently licensed physician designated by the Credentials Committee. Such confirmation may include a physical and/or mental health examination conducted by a health care professional of the Credentials Committee's choosing.
  5. Litigation history. Explanation of the existence of any prior or current lawsuits, settlements, or judgments, including malpractice claims.
  6. Exclusions. Confirm absence of exclusions from participation in Medicare, Medicaid, and Tricare.
- d. By applying for appointment to the Medical Staff, each applicant thereby signifies a willingness to appear for interviews in regard to the application, pledges to provide for continuous care of said applicant's patients, pledges to inform the Hospital (this is a continuous requirement) of any changes in membership or privileges at other hospitals whether voluntarily or involuntary; sanctions or investigative proceedings by third party payors, state medical board orders, loss of medical license, DEA certificate, DPS certificate or professional liability insurance, authorizes the Hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character and ethical qualifications, consents to the Hospital's inspection of all records and documents that may be material to an evaluation of the applicants professional qualifications and competence to carry out the clinical privileges requested as well as of the applicant's moral and ethical qualifications for staff membership, releases from any liability all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluation of the applicant and the applicant's credentials, and releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.
- e. The application form shall include a statement that the physician has received and been oriented to the Medical Staff Bylaws, Rules and Regulations and policies and procedures, and that the applicant agrees to abide by these; and, that the applicant agrees to be bound by the terms thereof without regard to whether or not membership and/or clinical privileges is granted in all matters relating to consideration of the application.
- f. Each applicant for appointment or reappointment to the Medical Staff or for clinical privileges shall be obligated to supplement his/her responses to questions, or requests for information on the application form after the application has been submitted, if a response or information given was incorrect or incomplete, or is no longer correct or complete due to a change in circumstances. The applicant for appointment, reappointment, and/or the grant of clinical privileges has the burden to produce evidence necessary for appropriate evaluation of the application and failure to provide any requested information will result in a finding of incomplete application.

## **SECTION 2. Appointment Process**

- a. Within ninety (90) days after receipt of the application for membership and privileges and once all information has been verified and required supporting documentation has been obtained inclusive of querying the National Practitioner's Data Bank, the Credentials Committee, through its chairperson, shall make a written report of its evaluation to the Medical Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of character, professional competence, qualifications and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the department chair or section chief in the service which privileges are sought, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by the applicant. Every department chair in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report. Together with its report, the Credentials Committee shall transmit to the Medical Executive Committee the completed application and a recommendation that the practitioner be appointed to the Medical Staff with the requested clinical privileges or rejected for Medical Staff membership and privileges, or that the application be deferred for further consideration.
- b. At its next regular meeting, or within thirty (30) days after receipt of the application and the report and recommendation of the Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the Governing Board that the practitioner be appointed to the Medical Staff, that the practitioner be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

The Governing Board shall take final action on a completed application within sixty (60) days after a completed application is received with report and recommendation of the Medical Executive Committee.

The applicant shall be notified in writing of the final action taken by the Governing Board, including a reason for denial or restriction of privileges requested, not later than twenty (20) days after the date on which the final action is taken.

- c. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within ninety (90) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership.
- d. When the recommendation of the Medical Executive Committee is favorable to the practitioner, the application shall be promptly forwarded, together with all supporting documentation, to the Governing Board.
- e. When the recommendation of the Medical Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the practitioner shall promptly be notified by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Board until after the practitioner has exercised or has been deemed to have waived the right to a hearing as provided in Article IX of these Bylaws.

- f. If, after the Medical Executive Committee has considered the report and recommendations of the Hearing Committee and the hearing record, the Medical Executive Committee's reconsideration and recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph d. of this Section 2. If such recommendation continues to be adverse, the applicant shall be promptly notified by certified mail, return receipt requested. Such recommendation and documentation shall be forwarded to the Governing Board, but the Governing Board shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived the rights to an appellate review as provided in Article IX of these Bylaws.
- g. At its next regular meeting, but not later than sixty (60) days, after receipt of a favorable recommendation, the Governing Board or its Executive Committee shall act in the matter. If the Governing Board's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the applicant shall be promptly notified of such adverse decision, within twenty (20) days, along with the reason for denial or restriction of privileges, by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived the rights under Article IX of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- h. At its next regular meeting, but not later than sixty (60) days, after all of the practitioner's rights under Article IX have been exhausted or waived, the Governing Board or its duly authorized committee shall act in the matter. The Governing Board's decision shall be conclusive, except that the Governing Board may defer final determination by referring the matter for further reconsideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence in the matter, if any, the Governing Board shall make a decision either to appoint the practitioner to the staff or to reject the practitioner for staff membership. All decisions to appoint shall include a delineation of the clinical privileges, which the practitioner may exercise.
- i. Whenever the Governing Board's decision will be contrary to the recommendation of the Medical Executive Committee, the Governing Board shall submit the matter to a joint committee composed of an equal number of members from the Governing Board and Medical Executive Committee for review and recommendation and shall consider such recommendation before making its decision final.
- j. When the Governing Board's decision is final, it shall send notice promptly of such decision through the administrator or the secretary of the medical staff, to the chairperson of the Medical Executive Committee, and of the department concerned, and by certified mail, return receipt requested, to the practitioner.

### **SECTION 3. Reappointment Process**

An application for reappointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board.

- a. Every department chair in which the practitioner seeks clinical privileges shall provide the

Credentials Committee with specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report. Together with its report, the Credentials Committee shall transmit to the Medical Executive Committee the completed application and a recommendation that the practitioner be reappointed to the Medical Staff with the requested clinical privileges or rejected for Medical Staff membership and privileges, or that the application be deferred for other consideration. The reason for any change in staff status or clinical privileges shall be documented.

- b. Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based upon the individual's current competency for requested clinical privileges, current licensure, DEA & DPS number (if applicable), professional liability insurance renewal, verification of hospital affiliations, changes in membership or privileges at other hospitals whether voluntarily or involuntary; challenges to any licensure or registration; voluntary or involuntary relinquishment of any license or registration; voluntary and involuntary limitation, reduction or loss of clinical privileges; Agreed Orders with state medical boards or medical societies, any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant for reappointment; sanctions or investigative proceedings by third party payors, loss of professional liability insurance, documentation of the practitioner's health status, professional performance, judgment, and clinical technical skills, as indicated through results of Ongoing Professional Practice Evaluation (OPPE) when available (FPPE or OPPE data from other hospitals may be used), or two (2) peer recommendations from peers in the same professional discipline when sufficient practitioner specific data is not available, evidence of required participation in medical staff review, receipt of continuing medical education inclusive of one (1) CME hour of risk management education, an appraisal by the chairperson of the department or section chief of the applicable service, compliance with Medical Staff Bylaws and Rules and Regulations and policies and procedures of the Medical Staff, use of the Hospital's facilities for patients, relations with other practitioners and general attitude toward patients, the Hospital and the public.
- c. The Medical Executive Committee shall review the Hospital personnel information form and other relevant information available to the reappointment of the staff member, and recommend to the Governing Board that appointment be either renewed, renewed with modified staff category, department and section affiliation and/or clinical privileges, or terminated. The reason for change in staff status or clinical privileges shall be documented.
- d. The staff member seeking reappointment shall, if requested by the Medical Executive Committee as part of the reappointment appraisal, be willing to undergo physical or psychiatric examination. Refusal by the staff member to undergo such examination shall be cause to initiate the termination of staff membership.
- e. Thereafter, the procedure provided in Section 2 of this Article V, relating to recommendations on applications for initial appointment shall be followed.

**ARTICLE VI: EXPEDITED PROCESS FOR GRANTING PRIVILEGES**  
**(Board Credentials Sub-Committee)**

## **SECTION 1. Expedited Governing Body (Board Sub-Committee)**

- a. Composition: This committee shall consist of at least two (2) voting members of the Governing Body.
- b. Duties: The Board Subcommittee shall receive and act on behalf of the Board regarding positive recommendations from the Medical Executive Committee concerning appointments, reappointments or renewal or modification of clinical privileges.
- c. Meetings: This meeting shall convene as soon after every Medical Executive Committee as possible.
- d. Eligibility:
  1. If any of the following has occurred, the applicant will be ineligible for the expedited process:
    - The applicant submits an incomplete application,
    - The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
  2. If any of the following has occurred, the applicant will be evaluated on a case-by-case basis and usually results in ineligibility for this process:
    - There is a current challenge or a previously successful challenge to licensure or registration.
    - The applicant has received an involuntary termination of medical staff membership at another hospital
    - The applicant has received involuntary limitation, reduction, denial or loss of clinical privileges
    - The Hospital determines that there has been either an unusual pattern of or an excessive number of professional liability actions resulting in a final judgment against the applicant.
- e. Ratification: The Governing Body shall ratify the decision(s) made by this Board Sub-Committee.

## **ARTICLE VII: CLINICAL PRIVILEGES**

### **SECTION 1. Clinical Privileges Restricted**

- a. Every practitioner by virtue of medical staff membership or otherwise, shall, in connection with such membership, be entitled to exercise only those privileges specifically granted by the Governing Board, except as provided in Sections 2 and 3 of Article VII.
- b. Confirm the absence of any physical or mental condition, which could affect the member's ability to exercise the clinical privileges requested safely and competently.
- c. Privileges granted to applicants for the Medical Staff shall be recommended to the Medical Executive Committee of the Medical Staff by the Credentials Committee.

- d. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the quality of care and professional competency and proficiency of the practitioner.
- e. Applications for additional clinical privileges must be in writing. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privileges desired and the applicant's relevant recent training and/or experience must be stated. For clinical privileges for which there are no applicable criteria, the resources necessary to support each new requested privilege must be determined. Such applications should be processed in the same manner as applications for initial appointment.
- f. Privileges granted to dentists/oral and maxillofacial surgeons and podiatrists shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists/oral surgeons and podiatrists shall be under the supervision of the chairperson of the department of surgery.
- g. All podiatric and dental/oral maxillofacial patients shall receive the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff shall be responsible for the care of medical problems that may be present upon admission or that may arise during hospitalization. Dental/oral maxillofacial surgeons and podiatrists are responsible for their part of their patient's history and physical examination.
  - 1. All qualified practitioners must complete a history and physical within twenty-four (24) hours after admission or before major diagnostic or therapeutic intervention, whichever occurs first. An Inpatient History and Physical shall at a minimum include an Admitting or Provisional Diagnosis; History of Present Illness; Medications; Allergies; Past Medical and Surgical History; Family History; Review of Systems; Physical Exam; and Plan of Care. The Outpatient History and Physical shall at a minimum include a Chief Complaint; Diagnosis; Allergies, Medications, Physical Exam; and Plan of Care. A durable typed copy of a complete history and physical done before the patient is admitted may be used in the Hospital record, providing the history and physical was completed within thirty (30) days prior to the admit date and was done by a member of this Hospital staff. When so used, the History and Physical must be updated within twenty-four (24) hours after admission and prior to procedure, and must be in the admission note which includes all additional history changes or additional physical findings. The medical History and Physical shall be recorded in the patient's medical record within twenty-four (24) hours after admission. The only exceptions are the established OB record; the Trauma Services Admission/Consultation Note; the Abbreviated H&P which may be utilized in those situations where transcription is not practical; and the Physician Pre-sedation Assessment History and Physical. In elective surgery the History and Physical must be completed in accordance with the policy set forth in the Rules and Regulations.
  - 2. All *in-patients and/or out-* patients requiring moderate or deep sedation/analgesia shall have a documented History and Physical or Emergency Department Physician Assessment by the healthcare provider at the time of moderate or deep sedation/analgesia. The Physician Pre-Sedation Assessment History & Physical or the Abbreviated H&P may be used for sedation.
  - 3. Patients converted from outpatient status to inpatient status must have a History

and Physical which meets the applicable inpatient History and Physical requirements within 24 hours of change of status.

## **SECTION 2. Emergency Privileges**

In the case of an emergency, any practitioner member of the Medical Staff, to the degree permitted by his license and regardless of department or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this Section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

## **SECTION 3. Observation Rights**

A non-credentialed/non-privileged practitioner wishing to observe a credentialed/privileged practitioner must contact the medical staff office and provide the following: 1) documentation of proper TB Vaccination, 2) a letter from the sponsoring practitioner agreeing to responsibility, and 3) obtaining written/verbal consent of patient.

## **SECTION 4. Educational Privileges**

Educational privilege requests shall be in keeping with the requirements of the Texas Medical Board. Educational privileges require adequate notice to permit primary source verification of licensure; and, review and approval by the Department Chairman, Credentials Chairman, and President of the Medical Staff. The applicant must have and provide: a copy of current and unrestricted license to practice medicine, a current copy of their professional liability coverage; a copy of the practitioner's privilege list from the practitioner's primary hospital affiliation indicating approval of the specific procedure the physician is to proctor. The Medical Staff member requesting the educational consultation shall submit a letter of request specifically delineating the request, as well as the specific timeframe for such request. The sponsoring physician shall have the responsibility of obtaining written consent from the patient.

## **SECTION 5. Disaster Privileges**

Disaster privileges shall be granted on a case by case basis to a licensed independent practitioner (LIP) when the organization's emergency management plan has been formally activated or the organization is unable to meet immediate patient needs, i.e. community disaster/national disaster. Any licensed physician shall be permitted and assisted to do everything possible in the care of the patients within the scope of their license. The granting of disaster privileges shall be authorized by the President of the Medical Staff, the Medical Director, or an authorized designee. The specific practitioner shall present to the Medical Staff Office or Command Center and present to the chief administrative officer or president of the Medical Staff or their designee(s) a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport). In addition, the volunteer LIP must provide at least one of the following: (1) a current hospital picture identification card that clearly identifies the individual's professional designation; (2) a current license to practice; (4) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for

Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s); (5) identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority by a government entity having been granted by a federal, state, or municipal entity); (6) identification by a current member of the organization or medical staff who possesses personal knowledge regarding the individual's ability to act as a LIP during a disaster. Upon approval, a volunteer identification badge will be issued. A list of volunteer practitioners with disaster privileges will be posted in the patient care areas. Volunteer LIPs shall be assigned to work with another LIP within the scope of their license for organization oversight (direct oversight and mentoring). Once the immediate situation is under control, the medical staff office shall obtain primary source verification of the volunteer LIP's license. Primary source verification shall be completed within 72 hours from the time the volunteer LIP presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but shall be completed as soon as possible. The Hospital's Active Medical Staff will oversee the professional practice of the LIP with disaster clinical privileges and will decide within 72 hours whether or not to continue to the disaster clinical privileges initially granted.

Proof of professional liability insurance coverage shall also be provided or verified as soon as practically possible. Disaster privileges shall be terminated once the disaster no longer exists.

## **SECTION 6. Telemedicine Privileges**

Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications. Practitioners providing only telemedicine services to the Hospital from a distant site will not be appointed to the medical staff but must be granted privileges at this Hospital. The medical staff may recommend privileges to the governing body through one of the following mechanisms:

- a. The Hospital uses the credentialing and privileging decision made by the distant-site to make a final privileging decision. For the medical staff to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendation on privileges for the individual distant-site physicians and practitioners providing such services, the Hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:
  1. The distant site providing the telemedicine services is a Medicare-participating and Joint Commission-accredited hospital or ambulatory care organization,
  2. The individual distant-site physician or practitioner is privileged at the distant-site providing the telemedicine services for those services to be provided at the originating site, and the distant site provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or ambulatory care organization,
  3. The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the Hospital whose patients are receiving the telemedicine services is located,
  4. Provide proof of malpractice insurance in the type, amount and duration required by the Hospital, and
  5. With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services (originating site),

- the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients; and all complaints the hospital has received about the distant-site physician or practitioner.
- b. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization. Once the medical staff makes its recommendation regarding the privileging of the telemedicine provider, it then must go through the remainder of the credentialing process for a decision regarding approval by the Board.
  - c. The Hospital fully privileges and credentials the practitioner.
  - d. The Distant Site will attest that it has privileged the practitioner and the practitioner is licensed in Texas.
  - e. The services of the Distant Site practitioners shall be subject to Focused and Ongoing Professional Practice Evaluations, these Bylaws, Rules and Regulations and Hospital policies.

Once there is approval of a recommendation for privileges from the medical staff, the governing body shall decide whether to grant privileges through the usual credentialing process.

## **SECTION 7. Temporary Privileges**

- a. There are two circumstances in which Temporary Privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances are:
  - 1. To fulfill an important patient care, treatment and service need. An example would be if a specific physician has the necessary skills to provide care to a patient that no physician currently privileged possesses. These Temporary Privileges may be granted on a case-by-case basis when an important patient care need mandates an immediate authorization to practice.
    - Privileges may be granted for a limited period of time or for a patient specific case
    - When temps are granted to meet an important care need, the organized Medical Staff verifies current licensure and current competence.
  - 2. When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Governing Board. Examples would include an individual applying for privileges at the Hospital for the first time; an individual currently holding clinical privileges who is requesting an additional privilege(s); and an individual who is in the reappointment/recredentialing process and is requesting one or more additional privileges.
    - Privileges may be granted for a period of up to 120 days.
    - Temporary privileges under this category may be granted by the organized Medical Staff upon verification of the following:

- Current Licensure
  - Relevant training or experience
  - Current competence
  - Ability to perform the privileges requested
  - Other criteria required by the medical staff bylaws
  - A query and evaluation of the NPDB information
  - A complete application
  - No current or previously successful challenge to licensure or registration
  - No subjection to involuntary termination of medical staff membership at another organization
  - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
  - Documentation of current immunizations as required pursuant to the Hospital Immunization Policy.
  - Evidence of current professional liability insurance with coverage satisfactory to the Hospital.
- b. The Department Chairperson responsible for supervision may impose special requirements of consultation and reporting. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and/or its Medical Staff control all matters relating to the exercise of clinical privileges.
- c. Temporary Privileges are recommended by the Department Chair, Credentials Committee Chairman, and President of the Medical Staff and approved by the Administrator/CEO or designee.
- d. Termination. The President of the Medical Staff or the Chief Executive Officer, after consultation with the appropriate Department Chairman and/ Section Chief, may on the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, and may at any other time terminate any or all of a practitioner's temporary privileges, provided that where the life or well-being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension as outlined in these Bylaws. In the event of any such termination, the Section Chief/Department Chairman responsible for supervision shall assign the practitioner's patients then in the Hospital to another practitioner. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.
- e. Rights of the Practitioner. A practitioner is not entitled to the procedural rights outlined in Article IX of these Bylaws because his request for temporary privileges is refused or as long as the routine process for granting of privileges is ongoing.

### **ARTICLE VIII: CORRECTIVE ACTION**

Corrective action against any member of the Medical Staff, including the appeal of any adverse

action by any properly constituted professional review body, shall be conducted pursuant to these Bylaws.

### **SECTION 1. Procedure**

- a. Whenever the activities, professional conduct or clinical practice of any member with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital or contrary to these Bylaws, the Rules and Regulations or Hospital Policies and Procedures, corrective action against such member may be requested by any officer of the Medical Staff, by the Chairperson of any Clinical Department, by the Chairperson of any standing committee of the Medical Staff, by the Administrator or by the Governing Board. All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request.
- b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the Medical Executive Committee shall forward such request to the Chairperson of the Department or Section wherein the member has such privileges. Upon receipt of such request, the Chairperson of the Department or Section shall immediately appoint an Ad Hoc Committee to investigate the matter.
- c. Within fifteen (15) days after the Department's receipt of the request for corrective action, the Departmental Ad Hoc Committee shall make a report of its investigation to the Medical Executive Committee. Prior to the making of such report, the member against whom corrective action has been requested shall have an opportunity for an interview with the Departmental Ad Hoc Investigating Committee. At such interview, the practitioner shall be informed of the general nature of the charges and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the Department and included with its report to the Medical Executive Committee. The Ad Hoc Committee may determine in its report that a claim has no merit.
- d. Within seven (7) days following receipt of a report from a Department following the Department's investigation of a request for corrective action involving reduction or suspension of clinical privileges, the Medical Executive Committee shall take action upon the request. If the corrective action should involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected member shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.
- e. The action of the Medical Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the member's staff membership

be suspended or revoked.

- f. Any recommendation by the Medical Executive Committee for reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff shall entitle the affected member to the procedural rights provided in Article IX of these Bylaws, as well as to any right(s) to alternative dispute resolution expressly contemplated by the Texas Health and Safety Code.
- g. The President of the Medical Executive Committee shall promptly notify the Administrator or his designee in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Administrator fully informed of all action taken in correction therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article VI, Section 2, and Article IX if applicable, of these Bylaws.

## **SECTION 2. Summary Suspension**

- 1. Any one of the following - the President of the Medical Staff, the Chairperson of a Clinical Department or Section, , the Medical Executive Committee of the Governing Board, or the Administrator or Acting Administrator with the concurrence of any of the aforementioned - shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to suspend summarily all or any portion of the clinical privileges of the practitioner, and such summary suspension shall become effective immediately upon imposition.
  - b. A practitioner whose clinical privileges have been summarily suspended lasting longer than 14 days shall be entitled to request that the Medical Executive Committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the Medical Executive Committee may be convened in accordance with Article IX of these Bylaws.
  - c. The Medical Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Medical Executive Committee does not recommend immediate termination of the summary suspension, the Affected Practitioner shall, also in accordance with Article IX, be entitled to request an appellate review by the Governing Board, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Governing Board.
  - d. Immediately upon the imposition of a summary suspension, the President of the Medical Executive Committee or responsible Departmental Chairperson shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

## **SECTION 3. Automatic (Administrative) Suspension**

- a. An administrative suspension of the Practitioner's clinical privileges may be made automatically by the Medical Staff Office based on a Practitioner's conduct as described in this Section 3. Unless otherwise stated, such administrative suspension shall be effective immediately upon imposition, and the Medical Staff Office shall deliver written or

verbal notice to the Affected Practitioner. The administrative suspension shall be limited in duration and shall remain in effect for the period stated or, if not stated, until resolved as set forth herein.

b. Automatic Suspension will occur under the following circumstances:

1. Licensure. If a Practitioner's license, certification or registration to practice in Texas lapses, the Practitioner's clinical privileges shall be suspended until the deficiency is corrected. If, within 90 days following the lapse, the Practitioner does not demonstrate the license, certification or registration has been renewed, the Practitioner's clinical privileges shall be automatically revoked.
2. DEA Certificate and DPS Registration. If a Practitioner's DEA certificate or DPS registration lapses, that Practitioner shall be immediately and automatically divested, of his or her clinical privileges to prescribe controlled substances. If said certificate or registration lapses and is required for medical practice, the Practitioner's clinical privileges will be suspended unless the Practitioner provides documentation from the DEA or DPS demonstrating that the expiration date of the DEA certificate or DPS registration has been extended. If, within 90 days following the lapse, the Practitioner does not demonstrate the DEA certificate or DPS registration has been renewed, the Practitioner's clinical privileges shall be automatically revoked.
3. Professional Liability Insurance. If a Practitioner fails to maintain professional liability insurance as set forth in these Bylaws, the Practitioner's clinical privileges will be suspended until the deficiency is corrected. If within ninety (90) days following the deficiency, the Practitioner does not provide evidence of required professional liability insurance, the Practitioner's clinical privileges may be automatically revoked.
4. Falsification. If an applicant of the Medical Staff falsifies an application for appointment, reappointment, or clinical privileges, the applicant will be immediately suspended; if upon investigation the falsification is confirmed, the suspension will become permanent.
5. Repetitious Infractions. If a Practitioner has been subject to at least three (3) administrative suspensions under this Section 3 within any consecutive twenty-four (24) month period, the Practitioner's clinical privileges may be immediately suspended by the Medical Executive Committee until the underlying act or failure to act giving rise to the administrative suspensions is addressed. If the underlying act or failure to act is not so addressed, the suspension will become permanent.
6. Reappointment. If a practitioner fails to return his/her reappointment packet prior to deadline, the practitioner's clinical privileges will be suspended until the reappointment is approved by the Governing Board. If within 90 days following reappointment expiration date, the practitioner has not complied, the Practitioner's clinical privileges may be automatically revoked.
7. Electronic Health Record (EHR) Training. If a practitioner fails to successfully complete ConnectCARE training his/her clinical privileges shall be suspended until such time as training is complete and documentation of completion is received in the Medical Staff Office.

8. A temporary suspension in the form of withdrawal of a practitioner's admitting and clinical privileges shall be imposed automatically after warning of delinquency for failure to complete medical records within the time specified in Rules and Regulations, Section B. No. 17 of these Bylaws. The suspension will be effective until medical records are completed,
9. Action by the State Board of Medical Examiners revoking or suspending a practitioner's license, or placing said practitioner on probation, shall automatically suspend all of the practitioner's privileges. If placed on probation, the practitioner's hospital standing shall be evaluated by the Medical Executive Committee of the Medical Staff and appropriate action shall be taken.
10. It shall be the duty of the President of the Medical Staff to cooperate with the Administrator in enforcing all automatic suspensions.
11. Exclusions. Any practitioner excluded from participation in Medicare, Medicaid &/or Tricare or any government funded healthcare program will be suspended immediately.
12. Felony. If a Practitioner is convicted of a felony, the Practitioner's scope of practice or scope of service shall be automatically revoked upon the Hospital receiving actual notice of the conviction.
13. Flu Vaccination. Failure to provide annual documentation of flu vaccination or a medical or religious waiver in a form acceptable to Hospital shall result in an automatic administrative suspension until such time as such documentation is provided to Hospital (see MFH Human Resources Universal Influenza Vaccine Program Policy, B-60.0).

**ARTICLE IX:**  
**HEARING AND APPELLATE REVIEW PROCEDURE**

**SECTION 1. Right to Hearing and to Appellate Review for Medical AND Allied Staff Members**

- a. When any practitioner receives notice of a recommendation of the Medical Executive Committee that, if ratified by decision of the Governing Board, will adversely affect the practitioner's exercise of clinical privileges or appointment to or status as a member of the Medical Staff or Allied Health Professional Staff the practitioner shall be entitled to a hearing before an Ad Hoc Committee of the Medical Staff. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the Affected Practitioner, the practitioner shall be entitled to an appellate review by the Governing Board before the Governing Board makes a final decision on the matter.
- b. When any practitioner receives notice of a decision by the Governing Board that will affect the practitioner's exercise of clinical privileges or appointment to or status as a member of the Medical Staff or Advanced Allied Health Professional Staff, and such decision is not based on a prior adverse recommendation by the Medical Executive Committee of the Medical Staff with respect to which the practitioner was entitled to a hearing and appellate review, the practitioner shall be entitled to a hearing by a committee appointed by the Governing Board, and if such hearing does not result in a favorable recommendation, to

an appellate review by the Governing Board before the Governing Board makes a final decision on the matter.

- c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article IX to assure that the Affected Practitioner is accorded all rights to which the practitioner is entitled.

## **SECTION 2. Request for Hearing**

- a. The Administrator or his designee shall be responsible for giving prompt written notice of an adverse recommendation or decision to any Affected Practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested.
- b. The failure of a practitioner to request a hearing to which the practitioner is entitled by these Bylaws within thirty (30) days from receipt of notice of adverse action and in the manner herein provided shall be deemed a waiver of the practitioner's right to such hearing and to any appellate review the practitioner might otherwise have been entitled on the matter. The failure of a practitioner to request an appellate review to which the practitioner is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of the practitioner's right to such appellate review on the matter.
- c. When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee of the Medical Staff or of a Hearing Committee appointed by the Governing Board, the same shall thereupon become and remain effective against the practitioner pending the Governing Board's decision on the matter.
- d. When the waived hearing or appellate review relates to adverse decision by the Governing Board, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Governing Board provided for in Section 7 of this Article IX. In either of such events, the Administrator or his designee shall promptly notify the Affected Practitioner of the practitioner's status by certified mail, return receipt requested.

## **SECTION 3. Notice of Hearing**

- a. Within ten (10) days after receipt of a request for hearing from a practitioner entitled to the same, the Medical Executive Committee or the Governing Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Administrator or his designee, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall not be less than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made.
- b. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision, a list of the witnesses, and a summary of the rights of the practitioner.

## **SECTION 4. Composition of Hearing Committee**

- a. When a hearing relates to an adverse recommendation of the Medical Executive Committee, such hearing shall be conducted by an Ad Hoc Hearing Committee of not less than five (5) members of the Medical Staff appointed by the President of the Medical Staff in consultation with the Medical Executive Committee and one of the members so appointed shall be designated as Chairperson. Appointees shall not be in direct competition with the physician involved. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this Hearing Committee.
- b. When a hearing relates to an adverse decision of the Governing Board that is contrary to the recommendation of the Medical Executive Committee, the Governing Board shall appoint a Hearing Committee to conduct such hearing and shall designate one of the members of this Committee as Chairperson. The appointed Chairperson shall not be in direct competition with the physician involved. At least one representative from the Medical Staff, not in direct competition with the physician involved, shall be included on this Committee when feasible.

#### **SECTION 5. Conduct of Hearing**

- a. There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.
- b. An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee, and may be accomplished by the use of a court reporter, electric recording unit, transcription or by the taking of adequate minutes.
- c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived rights in the same as provided in Section 2 of this Article IX and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.
- d. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Ad Hoc Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.
- e. The Affected Practitioner shall be entitled to be accompanied and/or represented at the hearing by an attorney or other person of the practitioner's choice.
- f. Either a Hearing Officer, if one is appointed, or the Chairperson of the Hearing Committee or designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
- g. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of existence of any common law or statutory rule, which make evidence inadmissible over objection in civil or criminal actions. The practitioner for whom the

hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

- h. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members, some other Medical Staff member or its attorney to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Board, when its action has prompted the hearing, shall appoint one of its members or its attorney to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the Affected Practitioner shall thereafter be responsible for supporting the practitioner's challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.
- i. The Affected Practitioner and Hearing Committee shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the practitioner does not testify in the practitioner's own behalf, the practitioner may be called and examined as if under cross-examination. The practitioner may submit a written statement at the close of the hearing.
- j. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Affected Practitioner for whom the hearing was convened.
- k. Within twenty (20) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Medical Executive Committee or to the Governing Board, whichever appointed it and the Affected Practitioner. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Governing Board. Thereafter, the procedure to be followed shall be as provided in Section 2 of Article VI of these Bylaws. The Affected Practitioner has the right to the record of the proceedings, copies of which may be obtained by the practitioner upon payment of reasonable charges associated with the preparation thereof.

## **SECTION 6. Appeal to the Governing Board**

- a. Within ten (10) days after receipt of a notice by an Affected Practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the practitioner may, by written notice to the Governing Board delivered through the Administrator or his designee by certified mail, return receipt requested, request an appellate review by the Governing Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

- b. If such appellate review is not requested within ten (10) days, the Affected Practitioner shall be deemed to have waived the right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article IX.
- c. Within thirty (30) days after receipt of such notice of request for appellate review, the Governing Board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Administrator or his designee, by written notice sent by certified mail, return receipt requested, notify the Affected Practitioner of the same. The date of the appellate review shall not be less than thirty (30) days, nor more than forty-five (45) days, from the date of the receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than fifteen (15) days from the date of receipt of such notice.
- d. The appellate review shall be conducted by the Governing Board or by a duly appointed appellate review committee of the Governing Board of not less than three (3) members. To the extent possible based on the availability of Board members, no member of the appellate review committee will have been a member of the initial peer review hearing panel or a member of the Medical Executive Committee making an adverse determination that is subject to the appeal.
- e. The Affected Practitioner shall have access to the report and record and transcription, (if any) of the Ad Hoc Hearing Committee and all other material favorable or unfavorable, that was considered in making the adverse recommendation or decision against the practitioner. The Affected Practitioner shall have fifteen (15) days to submit a written statement in the practitioner's own behalf, in which those factual and procedural matters with which the Affected Practitioner disagrees, and subsequent reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Board through the Administrator or his designee by certified mail, return receipt requested, at least fifteen (15) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Executive Committee of the Medical Staff or by the Chairperson of the Hearing Committee appointed by the Governing Board and if submitted, the Administrator or his designee shall provide a copy thereof to the practitioner at least seven (7) days prior to the date of such appellate review by certified mail, return receipt requested.
- f. The Governing Board or its appointed review committee shall act as an appellate body. The Chairperson of the appellate review body shall be the Presiding Officer. The Chairperson will determine the order of procedure during the review, make all required rulings, and maintain decorum. The Governing Board shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e. of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the Affected Practitioner was justified and was not arbitrary or capricious. If an oral argument is requested as part of the review procedure, the Affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put

to the practitioner by any member of the appellate review body. The Medical Executive Committee or the Governing Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to said practitioner by any member of the appellate review body.

- g. New or additional matters not raised during the original hearing or in the Hearing Committee Report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Governing Board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.
- h. If the appellate review is conducted by the Governing Board, it may affirm, modify or reverse its prior decision, or in its discretion, refer the matter to the Medical Executive Committee of the Medical Staff for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.
- i. If the appellate review is conducted by a committee of the Governing Board, such committee shall, within seven (7) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Board affirm, modify or reverse its prior decision, or refer the matter to the Executive Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Board as above provided.
- j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Governing Board may be taken by a committee of the Governing Board duly authorized to act.

## **SECTION 7. Final Decision by Governing Board**

- a. Within seven (7) days after the conclusion of the appellate review, the Governing Board shall make its final decision in the matter and shall send notice thereof to the Medical Executive Committee and, through the Administrator or his designee, to the Affected Practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, the Governing Board shall refer the matter to a joint committee composed of an equal number of members from the Governing Board and Medical Executive Committee for further review and recommendation within fifteen (15) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Committee's recommendation has been received.
- b. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee of the Medical Staff, or by

- c. the Governing Board, or by duly authorized committee of the Governing Board, or by both. If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply or to proceed with the matter, the practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect with respect to the matter involved.

## **SECTION 8. Reporting**

- a. In accordance with Texas Occupations Code Section 160.003, if a determination is made that a practitioner in Texas poses a continuing threat to the public welfare through the practice of medicine, the person or committee must report relevant information in writing to the Texas Medical Board, or appropriate Board. This report must include:
1. The name of the practitioner;
  2. A description of the acts or omissions or other reasons for the action or, if know, for the surrender; and
  3. Such other information respecting the circumstances of the action or surrender, as the Secretary deems appropriate.
- b. In accordance with 42 U.S.C. Sections 11133, 11134, 11131, and Texas Occupations Code Section 160.002, to prevent loss of immunity from civil damages afforded by statute, the following professional review actions must be reported by the Hospital's authorized representative to the National Practitioners Data Bank and to the Texas Medical Board or appropriate Board:
1. Action that adversely affects the clinical privileges of a practitioner for a period longer than 30 days; or
  2. Acceptance of the surrender of clinical privileges of a practitioner (while the practitioner is under an investigation by the entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding).
- This duty may not be nullified through contract.
- c. To avoid being subject to a civil monetary penalty, the Hospital must also report payments made for the benefit of a physician, dentist, or other practitioner in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action against the practitioner. A payment resulting from a claim that is solely against an entity (e.g. Hospital, clinic, group practice) and that does not name an individual practitioner is not reportable. The information required to be reported shall be reported regularly (but not less often than monthly) to the NPDB and to the Texas Medical Board and or other appropriate Board and must include:
1. The name of the practitioner for whose benefit the payment is made;
  2. The amount of the payment;
  3. The name (if known) of any hospital with which the practitioner is affiliated or associated;
  4. A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and

5. Such other information as the Secretary determines is required for appropriate interpretation of information reported under this 42 U.S.C Section 11131.

To the extent the aforementioned state and federal laws change, this section shall conform to such changes without regard to whether an amendment has yet been adopted in accordance with these bylaws.

## **ARTICLE X: OFFICERS**

### **SECTION 1. Officers of the Medical Staff**

The officers of the Medical Staff shall be:

- 1) President (must be a physician or dentist)
- 2) President-Elect
- 3) Immediate Past-President
- 4) Secretary

### **SECTION 2. Qualification of Officers**

Officers must have been members of the Active Staff for not less than five (5) years at the time of nomination and election, and must remain members in good standing during their term of office. Failure of an officer to maintain good standing shall immediately vacate the practitioner from office.

### **SECTION 3. Election of Officers and Members-at-Large**

- a. Officers and Members-at-Large shall be elected at the fall meeting of the Medical Staff or by written ballot (via fax or electronic submission) at the direction of the Medical Executive Committee. Voting should be done in such a way to maintain the integrity of the anonymous vote. Only members of the Active Medical Staff shall be eligible to vote.

When there are three (3) or more candidates and no candidate receives a majority vote, the process of successive balloting shall apply, such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority vote is obtained by one candidate.

- b. The Nominating Committee shall consist of three (3) members of the Active Medical Staff, one of them the President-Elect, appointed by the President of the Medical Staff at least one (1) month before the fall meeting. This committee shall offer one nominee for each office and the list of nominees shall be provided to each member of the Active Medical Staff prior to the meeting.
- c. Nominations may also be made from the floor at the time of the meeting. All nominees shall be approved by the Governing Board before taking office.

### **SECTION 4. Term of Office**

Officers and Members-at-Large shall serve their term of office as follows:

President-Elect: The President-Elect of the Medical Staff shall serve two (2) years as President-

Elect, two (2) years as President and two (2) years as immediate Past-President.  
Secretary: The Secretary of the Medical Staff shall serve for a two (2) year period.

Members at large: The Members at Large shall serve for a two year (2) period. Officers shall serve their term from their election date or until a successor is elected.

#### **SECTION 5. Vacancies in Office**

Vacancies in office during the medical staff year, except for the presidency, shall be filled by the Medical Executive Committee of the Medical Staff and approved by the Governing Board. If there is a vacancy in the office of the President, the President-Elect shall serve out the remaining term.

#### **SECTION 6. Duties of Officers**

- a. President: The President shall serve as the Chief Administrative Officer of the Medical Staff to:
1. Act in coordination and cooperation with the Administration in all matters of mutual concern within the Hospital;
  2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
  3. Preside on the Medical Staff Executive Committee with full voting privileges at all meetings of the Medical Staff Executive Committee;
  4. Serve as ex-officio member of all other Medical Staff committees without vote;
  5. Be responsible for the annual review and enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
  6. Appoint Committee members to all standing, special and multi-disciplinary medical staff committees except the Medical Executive Committee;
  7. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Board and to the Administrator or his designee;
  8. Receive and interpret the policies of the Governing Board to the Medical Staff and report to the Governing Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
  9. Be responsible for the educational activities of the Medical Staff;
  10. Be the spokesperson for the Medical Staff in its external professional and public relations; and
  12. Serve as immediate Past-President on the Executive Committee for a period of two (2) years.

- b. President-Elect: In the absence of the President, the President-Elect shall assume all the duties and have the authority of the President. The President-Elect shall be a member of the Medical Executive Committee of the Medical Staff. The President-Elect shall automatically succeed the President when the latter fails to serve for any reason.
- c. Immediate Past-President: The duties of the immediate Past-President are usually advisory in nature. The immediate Past-President shall be a member of the Medical Executive Committee of the Medical Staff.
- d. Secretary: The Secretary shall be a member of the Medical Executive Committee of the Medical Staff. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to the office. Where there are funds to be accounted for, the Secretary also shall act as Treasurer.
- e. Members at Large: The Members at Large shall be members of the Medical Executive Committee with voting rights.

**SECTION 7. Removal of Officers and Members-at-Large**

Any officer may be removed by any of the following:

- a. The Governing Board;
- b. A two-thirds vote of the Active Medical Staff present at a special meeting if such vote of the Active Medical Staff is ratified by the Governing Board.
- c. Grounds for removal may include any of the following:
  - 1. Failure to perform the duties of office in a timely and appropriate manner; or
  - 2. Failure to satisfy continuously the qualifications of office; or
  - 3. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of office.

**ARTICLE XI: CLINICAL DEPARTMENTS**

**SECTION 1. Organization of Clinical Departments and Services**

The Medical Staff shall be organized into three (3) departments, Medicine, Emergency and Surgery, and shall have a chairperson who shall be responsible for the overall supervision of the clinical work within the department. The three (3) departments shall be comprised of various clinical sections. Each section shall have a chief appointed by the Medical Executive Committee. Medical staff peer review shall be accomplished within the three organized departments, within the sections or within service meetings. Any physicians within the clinical departments or sections or services may organize themselves to discuss a particular issue, hold educational functions or, for whatever reason they deem necessary. Any clinical section if organized shall be required to hold regular meetings. Only when sections or services are making formal recommendations to a department or are conducting medical peer review will a documented record be required from the chief.

The clinical sections of the Medical Staff which shall be assigned to the Department of Surgery are as follows: General and Vascular Surgery, Anesthesiology, Cardiothoracic Surgery, Oral and Maxillofacial Surgery/Dentistry, Neurosurgery, Obstetrics/Gynecology, Ophthalmology, Otolaryngology, Orthopedics, Pain Management, Pathology, Plastic Surgery, Podiatry, Trauma and Urology.

The clinical sections of the Medical Staff which shall be assigned to the Department of Medicine are as follows: Family Practice, Internal Medicine, Neonatology, Neurology, Pediatrics, Psychiatry, Radiology, Critical Care, Oncology, Nephrology and Gastroenterology.

The clinical sections of the Medical Staff which shall be assigned to the Cardiovascular Service are Cardiology and Cardiothoracic Surgery.

The clinical sections of the Medical Staff which shall be assigned to the Neurosciences Service are: Neurology, Neurosurgery, Pain Management and Psychiatry.

The clinical sections of the Medical Staff which shall be assigned to the Maternal/Child Service are Obstetrics/Gynecology and Pediatrics.

## **SECTION 2. Selection and Tenure of Department Chairperson and Section Chief**

- a. Each department chairperson and section Chief shall be a member of the Active Category staff best qualified by training, experience and demonstrated ability for the position and shall be certified by their specialty board.
- b. Each department chairperson and section Chief shall be appointed by the Governing Board upon recommendation of the Medical Executive Committee and shall serve a two-year term.
- c. Removal of a department chairperson or Section Chief and section Chief during a term of office may be initiated by any of the following:
  1. The Governing Board; or
  2. The Medical Executive Committee if ratified by the Governing Board; or
  3. A two-thirds majority vote of all Active Category medical staff members of the department if ratified by the Medical Executive Committee and the Governing Board.

Grounds for removal may include any of the following:

1. Failure to perform the responsibilities of the department chairperson or Section Chief in a timely and appropriate manner; or
2. Failure to satisfy continuously the qualification of department chairperson or Section Chief; or
3. Physical infirmity that renders the department chairperson or Section Chief incapable of fulfilling the responsibilities of office;

## **SECTION 3. Qualifications and Responsibility of Department Chairperson**

a. Qualifications:

Each department chairperson shall be a member of the Active Medical Staff, willing and able to discharge the functions of the office and shall be board certified by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

b. Responsibilities: Each department chairperson is responsible for the following:

1. Clinically related activities of the department
2. Administratively related activities of the department, unless otherwise provided by the Hospital
3. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
4. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department
5. Recommending clinical privileges for each member of the department
6. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
7. Integration of the department or service into the primary functions of the organization
8. Coordination and integration of interdepartmental and intradepartmental services
9. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
10. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
11. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
12. Continuous assessment and improvement of the quality of care, treatment, and services
13. Maintenance of quality control programs, as appropriate
14. Orientation and continuing education of all persons in the department or service
15. Recommending space and other resources needed by the department or service

c. Each department chairperson shall be a member of the Active Medical Staff, willing and able to discharge the functions of the office and shall be board certified. Each department chairperson is responsible for the following:

1. Clinically related activities of the department
2. All administratively related activities of the department, not provided for by the Hospital
3. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
4. Recommending clinical privileges for each practitioner in the department. Chiefs of the specific sections will make recommendations for clinical privileges
5. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the department or organization

6. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges including conducting Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE)
- d. Each department chairperson shall collaborate with the administrative designee of each Department with:
1. The integration of the department or service into the primary functions of the organizations
  2. The coordination and integration of interdepartmental and intradepartmental services
  3. The development and implementation of policies and procedures that guide and support the provision of care, treatment and services
  4. The continuous assessment and improvement of the quality of care and services provided
  5. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services
  6. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services
  7. The maintenance of quality control programs, as appropriate
  8. The orientation and continuing education of all persons in the department or service
  9. The recommendations for space equipment, staffing and financial resources needed by the department or service to support each clinical privilege prior to offering new privileges.

Advanced Allied Health Professionals whose patient care duties are of a nature that must be quality controlled by direct Medical Staff evaluation shall be initially evaluated and periodically reevaluated as necessary by their sponsoring physician and the department chairperson or the chief of the appropriate section. Evaluation shall focus upon the allied health professional's qualifications, status, clinical duties, FPPE & OPPE and job responsibilities with respect to the risk to the patient in performance of those responsibilities. Department chairpersons shall continue to function until new chairpersons are assigned and approved by the Governing Board.

#### **SECTION 4. Functions of Sections and Services**

- a. Each clinical section may establish its own criteria consistent with the policies of the Medical Staff and of the Governing Board, for the granting of clinical privileges. The section may make recommendations to the Medical Executive Committee as to section chief.

Clinical privileges that cross section, specialty and/or department lines will be reviewed and recommended for approval by affected sections, specialties and/or departments.

- b. Each section may establish a method to determine the appropriateness of patient care.
- c. Each clinical section and service shall determine the number of meetings it will hold each year, unless otherwise approved by the Medical Executive Committee, to consider the findings, conclusions, recommendations and actions taken by the ongoing monitoring and

evaluation of section activities conducted by its members. Clinical sections may elect to meet together as a service to facilitate communication between sections and conduct business, such as peer review, that may benefit from interaction between sections.

- d. Only when sections or services are making formal recommendations to a department or are conducting medical peer review will a documented record be required from the chief.

## **SECTION 5. Assignment to Departments & Medical Staff Categories**

The Medical Executive Committee, after consideration of the recommendations of the clinical departments as transmitted through the Credentials Committee, recommends initial departmental assignments and medical staff categories for all medical staff members and for all other approved practitioners with clinical privileges.

## **ARTICLE XII: MEDICAL STAFF PEER REVIEW COMMITTEES**

### **SECTION 1. Medical Executive Committee**

The Organized Medical Staff has delegated to the Medical Executive Committee the authority to carry out responsibilities of the Medical Staff, including the Medical Staff's responsibility to be accountable to the governing board for the quality of medical care provided to patients. Therefore, the Medical Executive Committee shall act on the authority of the Board of Trustees on matters of a medical nature, and shall perform any other duties that the governing board may require in order to promote quality of care.

- a. Composition: The Medical Executive Committee shall be a standing committee and may include physicians and other licensed independent practitioners of any discipline or specialty who have at least five (5) years membership on the Active Category Medical Staff at time of elections. The majority of voting Medical Staff Executive Committee members is fully licensed doctors of medicine or osteopathy actively practicing in the Hospital. The Medical Executive Committee shall consist of the officers of the Medical Staff, and three (3) other members elected for two (2) year terms, the Chairman of the Credentials Committee, and the Department Chairpersons. The secretary and one member will be elected on alternate years with the other two (2) members. The Administrator of the Hospital or designee, Vice-President of Medical Affairs and System Chief Quality Officer shall attend each Medical Executive Committee meeting on an ex officio basis without vote. The primary function of the organized Medical Staff or Medical Executive Committee is to approve and amend Medical Staff Bylaws and to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges.

Self-governance of the organized Medical Staff includes the following:

1. Initiating & developing the Medical Staff Bylaws, Rules and Regulations;
2. Recommending approval and disapproval of amendments to the Medical Staff Bylaws to the Medical Staff and Governing Board;
3. Selecting and removing Medical Staff officers;
4. Determining the mechanism for establishing and enforcing criteria and

standards for Medical Staff membership;

5. Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;
6. Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges including requesting evaluations where there is doubt about an applicant's ability to perform the privileges requested; and,
7. Engaging in performance improvement activities.

b. Duties: The duties of the Medical Executive Committee shall be:

1. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
2. To work with the Governing Board to define their shared and unique responsibilities;
3. To work with the Governing Board and senior leaders to identify skills required of individual leaders within management;
4. To work with the Governing Board and senior leaders to create the Hospital's mission, vision and goals;
5. To work with the Hospital's Governing Board and senior leaders to define what constitutes a conflict of interest that could affect safety and quality;
6. To work with the Hospital's Governing Board and senior leaders in developing a policy that defines how conflict of interest will be addressed;
7. To work with senior leaders in developing processes that support efficient patient flow;
8. To act on behalf of the Medical Staff between meetings;
9. To coordinate the activities and general policies of the various departments;
10. To receive and act upon reports and recommendations from Medical Staff committees, clinical departments and any ad hoc committees;
12. To implement policies of the Medical Staff not otherwise the responsibility of the departments;
13. To provide liaison between the Medical Staff and the administrator and the Governing Board;
14. To make recommendations on Hospital management matters (for example, long range planning) to the Governing Board through the administrator;

15. To fulfill the Medical Staff's accountability to the Governing Board for promoting patient safety and the quality of medical care;
  16. To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;
  17. To provide for the preparation of all meeting programs, either directly or through delegation to a Program Committee or other suitable agent;
  18. To review the credentials of all applicants and to make recommendations for staff membership, assignment to department and delineation of clinical privileges to the Governing Board;
  19. To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges;
  20. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
  21. To recommend appointment of the department chairpersons, section chiefs and committee members in accordance with these Bylaws, Rules and Regulations;
  22. To be responsible for the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities;
  24. To provide oversight in the process of analyzing and improving patient satisfaction;
  25. To keep regular minutes of their proceedings and report any relevant information at each general staff meeting or to the Governing Board, as appropriate
- c. Meetings: The Medical Executive Committee shall meet at least six times per year.

## **SECTION 2. Credentials Committee**

- a. Composition: The Credentials Committee shall consist of at least six (6) members who shall have Active Category Medical Staff membership for at least two (2) years at the time of appointment selected on a basis that will insure representation of the major clinical specialties and the medical staff at large and the Chief Nursing Officer or designee. The primary focus of this committee is the assessment of information regarding three critical parameters; current licensure; education and relevant training; and experience, physical ability and current competence to perform the requested privilege and to carry out patient care activities. This process may include an assessment for proficiency in the following six areas of General Competencies adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. Those six areas are: Patient Care; Medical/Clinical Knowledge; Practiced-Based

Learning and Improvement; Interpersonal and Communication Skills; Professionalism; and, System-Based Practice.

- b. Duties: The duties of the Credentials Committee shall be:
  - 1. To review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Articles VI and VII of these Bylaws;
  - 2. To make a report to the Medical Executive Committee on such applicant for medical staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges;
  - 3. To review periodically all information available regarding the competence of all practitioners privileged through the medical staff process and as a result of such reviews to make recommendations to the Medical Executive Committee for the granting of privileges, reappointments and the assignment of practitioners to the various departments or services as provided in Articles V, VI and VII of these Bylaws; and
  - 4. To investigate any breach of ethics that is reported to it.
- c. Meetings: The Credentials Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions and shall send a record of its proceedings to the Medical Executive Committee.
- d. Term: The Members shall serve for a three-five year period. Members shall serve their term from their election date or until a successor is elected.

### **SECTION 3. Hospital Practice Improvement Committee**

- a. Composition: The Hospital Practice Improvement Committee shall consist of the Chairpersons of Medicine and Surgery and Emergency Medicine, Section Chiefs, Hospital administrative personnel and others as approved by the Medical Executive Committee. The President of the Medical Staff will attend as needed.
- b. Duties: This committee shall be responsible for performance improvement activities to improve quality of care, treatment, services and patient safety. This is inclusive of the medical assessment and treatment of patients; and, the use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process. Additionally, this committee shall be responsible for ensuring that the Performance Improvement Plan as implemented by both clinical Hospital departments and medical staff is implemented, in accordance with Joint Commission standards. This Performance Improvement Plan includes but is not limited to medical staff monitoring and evaluation functions including the following:
  - 1. Operative and other procedures: Review for the appropriateness/justification for surgical and invasive diagnostic procedures based on predetermined screening criteria;

2. Blood and blood components: Review for appropriateness/justification for transfusion, transfusion reactions, blood ordering practices, adequacy of transfusion services, policies and procedures;
  3. Medical Records Review Function: Review of the timeliness and clinical pertinence of medical records.
  4. Utilization Review Function: Readmission review - utilization;
  5. Mortality Review: Review of all deaths for appropriateness of care and causal factors;
  6. Review, evaluation, investigation and/or consideration of root cause analyses, near misses, adverse outcomes, sentinel event data and patient safety issues as reported;
  7. Significant departures from established patterns of clinical practice.
- c. As a result of this monitoring, the chairman of the Hospital Practice Improvement Committee will provide information regarding ongoing performance monitoring to the Credentials Committee as appropriate.
  - d. Meetings: The Performance Improvement Council shall meet at least quarterly. The committee shall maintain a permanent record of its proceedings and transmit reports and/or recommendations to the Medical Executive Committee.

#### **SECTION 4. Pharmacy and Therapeutics Committee**

- a. Composition: Membership shall consist of at least five (5) representatives of the Medical Staff, the Hospital director of pharmacy, pharmacy personnel and Hospital administrative personnel as required.
- b. Duties: This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee will review any adverse drug reactions.
- c. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.
- d. Meetings: This committee shall meet at least quarterly. The committee shall maintain a permanent record of its proceedings and transmit reports and/or recommendations to the Medical Executive Committee.

#### **SECTION 5. Infection Control Committee**

- a. Composition: The committee shall consist of at least five (5) representatives from the Medical Staff including Pathology, Pediatrics, Obstetrics/Gynecology, Family Practice and Surgery Services.
- b. Duties: The Infection Control Committee shall be responsible for the surveillance of

inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities.

- c. Meetings: This committee shall meet quarterly, shall maintain a record of its proceedings and activities, and shall report quarterly proceedings to the Medical Executive Committee.

## **SECTION 6. Bylaws, Rules and Regulations Committee**

The Bylaws, Rules and Regulations Committee shall consist of members who shall have at least five (5) years membership on the Active Category Medical Staff at time of appointment. This Committee shall be on the alert to see that the Bylaws, Rules and Regulations of the Medical Staff are properly revised and kept up-to-date and shall make recommendations to the Medical Executive Committee for any changes in these bylaws relating to the Medical Staff. The Medical Staff Bylaws, Rules and Regulations shall be reviewed at least annually. Changes shall be presented to the Medical Staff for consideration and vote. If no changes documentation to support such review shall be recorded within the Medical Executive Committee minutes. Final action rests with the Governing Board.

## **SECTION 7. Executive Cancer Committee**

The Executive Cancer Committee shall be a multidisciplinary committee composed of no less than six (6) members of the Medical Staff representing the following disciplines: surgery, medical oncology, gynecology, diagnostic radiology, radiation oncology and pathology. The committee shall also include the cancer liaison physician, cancer registrar, and representatives of administration, nursing and care management. The committee may add members from other services and disciplines as may be deemed appropriate.

1. Objectives and Duties: This committee shall:
  - a. Organize, publicize, conduct and evaluate regular educational consultative cancer conferences that are multidisciplinary, Hospital-wide and patient oriented.
  - b. Assure that consultative services from all major disciplines are available to patients.
  - c. Plan and complete a minimum of two (2) patient care evaluation studies annually; one to include survival data and, if available, comparison data.
  - d. Make certain that cancer rehabilitation services are available and encourage a supportive care system for all patients with cancer.
  - e. The cancer registry should be used by the committee as a fundamental resource.
  - f. Shall conduct clinical quality review as requested by the chairman, which review shall be subject to the peer review privilege.

2. Meetings: This committee shall meet at least quarterly.
3. Reports: There shall be a written report of each meeting as to any action taken, data received or programs underway and evaluations deemed appropriate. The report shall state the names of those in attendance.

## **SECTION 8. Hospital Quality and Safety Committee**

- a. Composition: This committee shall consist of the Patient Safety Officer, a representative of the Medical Staff and Hospital administrative personnel.
- b. Duties: The Patient Safety Steering Committee shall be a multidisciplinary committee focused on effective improvement in the quality of patient care through the reduction of medical health care errors and minimization of factors that contribute to unintended adverse outcomes.
  1. Ongoing assessment using internal and external knowledge and experience to improve quality of care and prevent error occurrence. Aggregated occurrence data shall be reviewed to prioritize patient care safety efforts.
  2. Types of occurrences shall include:
    - Hazardous Condition: Any set of known circumstances that significantly increase the likelihood of a serious adverse outcome
    - Near Miss: Any process variation which did not affect patient outcomes but for which a recurrence carries a significant chance of a serious adverse outcome
    - Error: A process variation, either omission or commission, which actually occurred, and was discovered, having an unintended or adverse effect on patient outcome
    - Sentinel/Never Events: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- c. Meetings: The Patient Safety Steering Committee shall meet at least quarterly. The committee shall maintain a permanent record of its proceedings and transmit reports and/or recommendations to the Medical Executive Committee and Governing Board.

## **SECTION 9. Continuing Medical Education Committee**

- a. Composition: The committee Chairman, a Medical Staff member, will select members from the various medical specialties within the categories of the Medical Staff. Staff representatives from quality, risk management, care management, Medical Staff services and other relevant committees will participate as members of the CME committee. Committee members shall agree to serve for a minimum of two (2) years.
- b. Duties: The Committee shall be responsible for the oversight and approval of all continuing medical education within the Hospital and Clinics. Program content shall be instructive, physician driven and quality-related and inclusive of medical peer review complicated cases. Documentation and verification of CME participation will be maintained by record keeping software in the Education Department.

- c. Meetings: The Continuing Medical Education Committee shall meet as needed to meet state regulations.

### **SECTION 10. Critical Care Service Committee**

- a. Composition: Membership shall consist of representatives from the following specialties: critical care; trauma surgery; cardiology; cardiothoracic surgery; neurology; neurosurgery; hospitalist; general surgery; anesthesiology; emergency medicine; nephrology; palliative care; and infectious disease. Hospital personnel from areas such as ICU nursing managers; pharmacy; respiratory therapy, nutritional services and others on an as needed basis as identified by the committee chair will attend and participate as ex-officio members.
- b. Duties: This committee shall be responsible for the development, implementation and oversight of a clinical infrastructure that results in the improvement of care for the critically ill adult patient.
- c. The committee shall assist in the development, implementation and enforcement of critical care policies and procedures; development of critical care protocols; development implementation and monitoring of quality metrics; and development of interdisciplinary communication which promotes and improves the outcomes of critical care patients.
- d. Meetings: This committee shall meet at least quarterly. The committee shall maintain a permanent record of its proceedings and transmit reports and/or recommendations to the Medical Executive Committee.

### **SECTION 11. Special Committees**

Special committees shall be appointed from time-to-time as may be required to carry out properly the duties of the Medical Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Medical Executive Committee. They shall not have power of action unless such is specifically granted by the motion which created the committee.

### **SECTION 12. Automatic Resignation**

The revocation or resignation of a committee member's Medical Staff membership and/or appointment will serve as a resignation from the respective Committee.

## **ARTICLE XIII: MEDICAL STAFF MEETINGS**

### **SECTION 1. Meetings**

- a. Regular Meetings: Meetings of the General Medical Staff shall be held no less than annually. Frequency of Section and service meetings of the staff will be determined by the section or service and approved by the Medical Executive Committee. In addition to matters of organization, these meetings may include a report of the Medical Executive Committee and various committee chairpersons. These meetings shall include the findings, conclusions, recommendations and actions taken by the ongoing monitoring and evaluation of department activities conducted by its members.
- b. Officers and Members at Large for the ensuing year shall be elected at the annual meeting; or, may be elected via written ballot to eligible voters at the direction of the Medical

Executive Committee following distribution of the list of nominees to each member of the Active Medical Staff.

## **SECTION 2. Special Meetings**

- a. The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within ten (10) days after receipt of a written request stating the purpose of such meeting. The President shall designate the time and place of any special meeting.
- b. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be posted on the bulletin board in the physician's lounge not less than four days before the time and date of such meeting, by or at the direction of the President of the Medical Staff. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

## **SECTION 3. Quorum**

A quorum consists of those members present.

## **SECTION 4. Attendance Requirements**

Members of the Active and Courtesy Medical Staff Categories shall be required to participate in fifty percent (50%) of their assigned Section and/or Service meetings as applicable to their specialty; and one General Medical Staff meeting per year. Participation in Medical Staff peer review shall also be considered as meeting this requirement. Participation in Medical Staff peer review may be met through attendance at one of the following meetings: a Medical Staff section or service meeting or other multi-specialty medical staff peer review meeting. Failure to comply with this provision may result in disciplinary action up to and including loss of Medical Staff membership and privileges.

Medical Executive, Credentials, Performance Improvement Council, Pharmacy and Therapeutics, and the Infection Control Committees: Members of the Medical Executive Committee, Credentials Committee, Performance Improvement Council, Pharmacy and Therapeutics Committee, and the Infection Control Committee are expected to attend at least fifty percent (50%) of the meetings held.

## **SECTION 5. Notice of Meetings**

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than 5 days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at the proper address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

## **SECTION 6. Manner of Action**

The action of a majority of the members present at a meeting at which a quorum is present shall

be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat.

#### **SECTION 7. Rights of Ex Officio Members**

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum nor shall they be permitted to vote.

#### **SECTION 8. Minutes**

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and forwarded to the Medical Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.

### **ARTICLE XIV: PRACTITIONER RIGHTS**

#### **SECTION 1.**

Each physician on the Medical Staff has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve a difficulty working with his/her respective department chair, that physician may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

#### **SECTION 2.**

Any practitioner has the right to initiate a recall election of a medical staff officer and/or appointment of a department chair. A petition for such recall must be presented, signed by at least 25% of the members of the Active Staff. Upon presentation of such valid petitioner, the Medical Executive Committee will schedule a special general staff meeting for the purposes of discussing the issue and (if appropriate) entertain a no-confidence vote.

#### **SECTION 3.**

Any practitioner may call a general staff meeting. Upon presentation of a petition signed by 30% of the members of the active staff, the Medical Executive Committee will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

#### **SECTION 4.**

Any practitioner may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any physician may submit a petition signed by 30% members of the Active Medical Staff. When such petition has been received by the Medical Executive Committee, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

#### **SECTION 5.**

Any section/subspecialty group may request a department meeting when a majority of the members/subspecialists believe that the department has not acted appropriately.

#### **SECTION 6.**

This section is common to Section 1 through 5 above. This section does not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual “credentialing” actions. Section 7 and the Fair Hearing Plan provide recourse in these matters.

#### **SECTION 7.**

Any physician has a right to a hearing/appeal to the institution’s Fair Hearing Plan in the event any of the following actions are taken or recommended:

1. Denial of initial staff appointment;
2. Denial of reappointment;
3. Revocation of staff appointment;
4. Denial or restriction of requested clinical privileges;
5. Reduction in clinical privileges;
6. Revocation of clinical privileges;
7. Individual application of, or individual changes in, mandatory consultation requirements; and
8. Suspension (for reason of competence or conduct) of staff appointment or clinical privileges if such suspension is for more than 14 days.

### **ARTICLE XV: CONFLICT RESOLUTION MECHANISM**

Process for Managing Conflict between the Medical Executive Committee (MEC) and the Organized Medical Staff

For the purposes of these bylaws, the process for conflict management outlined below applies only to conflict between the MEC and the organized Medical Staff regarding adoption or amendment of medical rules and regulations, and/or policy.

Should there be disagreement between the MEC and the organized Medical Staff over the adoption or amendment of medical staff rules and regulations, and/or policy, the following shall occur:

- The MEC will inform the governing body that either they or the organized Medical Staff has adopted or amended medical staff rules and regulation, and/or policies, and that there is disagreement between the two bodies.
- The governing body shall appoint a special committee consisting of five individuals – one each from the MEC and the organized Medical Staff, and three members of the governing body – who are neither members of the MEC or of the organized Medical Staff, one of whom shall serve as Chair.
- The special committee shall review the adoption or amendment as well as the MEC’s reason for disagreement. By majority decision, the special committee will make a recommendation to

the governing body to either allow the adoption or amendment to be proposed, or to decline receiving said proposal.

- Based on the recommendation from the special committee, the governing body shall decide whether or not to receive the proposed adoption or amendment. The decision by the governing body is final. Both the MEC and the organized Medical Staff shall be notified in writing of the governing body's decision.

Nothing in this process is to be construed as preventing the organized Medical Staff from communicating directly with the governing body. The governing body will determine the method of communication in such matters.

## **ARTICLE XVI: PHYSICIAN RESPONSIBILITIES**

### **Section 1. Patient Safety**

It is the responsibility of each physician holding medical staff membership and privileges to report issues or occurrences impacting patient safety. This is inclusive of any suspected or actual unsafe practice. Any such communication shall be referred to the Hospital Performance Improvement Committee, Office of VPMA or Section Chief for purposes of Peer Review. Any such communication or report with respect to any practitioner made in good faith and without malice shall be privileged and confidential and as such work product of a Medical Staff peer review committee.

### **Section 2. Anesthesia, Surgical and Medical Informed Consent**

In keeping with the requirements of the Texas Medical Disclosure Panel it is the responsibility of each physician holding medical staff membership and privileges to provide the patient with information with which to make an informed decision regarding medical treatment or surgical intervention. This is inclusive of risks, benefits and alternatives to the medical treatment or surgical intervention. This information should be patient specific and in language and terms the patient can understand. The date and time informed consent is given to the patient must be documented in the medical record of the patient by the physician.

## **ARTICLE XVII: IMMUNITY FROM LIABILITY**

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this Hospital:

First, any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and confidential.

Second, such privilege shall extend to all persons, organizations and committees under applicable law including, without limitation, Governing Board, officers and administrative staff, and to third

parties who provide information to any of the foregoing authorized to receive, release or act upon the same. Third parties' means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Board or Medical Staff.

Third, there shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, such immunity shall apply to all acts, communications, reports, recommendation, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews, and (7) other Hospital, departmental, service or committee activities related to quality patient care and unprofessional conduct.

Fifth, the acts, communications, reports, recommendations and disclosures referred to in this Article XVII may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, each practitioner shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article XVII in favor of the individuals and organizations specified in paragraph second, subject to such requirements as may be applicable under the laws of Texas.

Seventh, the consents, authorizations, releases, rights, privileges and immunities provided by section 1 and 2 of Article V of these Bylaws in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XVII.

### **ARTICLE XVIII: RULES AND REGULATIONS**

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement safe and effective care. The Rules and Regulations shall become effective when recommended by the Medical Executive Committee, and approved by the Governing Board.

- a. Amendments of Rules and Regulations. The organized Medical Staff shall propose adoptions or amendments to the Medical Executive Committee. The Rules and Regulations may be amended at any regular or special meeting of the Medical Executive Committee. Such amendments shall become effective when approved by the Governing Board.
- b. Communication of Amendments to the Medical Staff. The Medical Executive Committee will provide reasonable notice of any proposed amendments to the Medical Staff.
- c. Provisional Amendments.
  1. In cases of a documented need, the Medical Executive Committee may provisionally adopt an urgent amendment to the Rules and Regulations without prior notification of the Medical Staff when necessary to comply with standards, laws, and regulations.

2. Should this occur, the Medical Executive Committee shall immediately notify the organized Medical Staff of the adoption or amendment in order that the Medical Staff has the opportunity for retrospective review and comment on the provisional amendment.
3. If there is a conflict over the provisional amendment, the process for resolving conflict between leadership groups as described in Article XV, Conflict Resolution Mechanism is implemented. If necessary, a revised amendment to the Rules and Regulations may be submitted to the governing board for action.
4. The Medical Executive Committee shall have authority to make amendments that are of a technical or typographical nature, without further approval or vote.

### **ARTICLE XXIX: AMENDMENTS**

The authority to formulate, adopt or amend the Medical Staff Bylaws resides with the organized Medical Staff and the Governing Body and cannot be delegated. Such authority and responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner.

a. Process for Routine Amendments to the Medical Staff Bylaws

1. Initiated by the Medical Executive Committee  
All proposed amendments to these Bylaws shall be referred to the Medical Executive Committee of the Medical Staff by the Bylaws Committee. The Medical Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the Medical Staff or at a special meeting called for such purpose with the vote adopting the same taken at the next succeeding meeting where a quorum is present; or, a copy of the proposed amendment(s) shall be provided to each staff member at least fourteen days (14) prior to the meeting at which time proposed amendments will be presented for vote; or, they may be voted on via written ballots via fax or electronic submission) to eligible voters at the direction of the Medical Executive Committee following discussion at one (1) Medical Staff meeting or following a mail out of proposed amendments at least fourteen (14) days prior to the submission of the written ballot. To be adopted, the amendment(s) shall require a simple majority vote of eligible voters present at time of such vote or a majority of the signed returned ballots. Amendments so made shall be effective when approved by the Governing Board.
2. Initiated by the Organized Medical Staff  
The organized Medical Staff shall have the ability to adopt Medical Staff Bylaws, rules and regulations, and/or policies, and/or amendments thereto, and propose them directly to the governing body. The following criteria must be met in order for an adoption or amendment to be considered a valid action by the organized Medical Staff.
  - The adoption or amendment must be in writing and signed by at least 51% of the voting members of the active category of the organized Medical Staff.

- The adoption or amendment cannot contravene or be inconsistent with federal, state, or local law, regulation, or accreditation standards set forth by The Joint Commission.
- b. If an adoption or amendment to rules and regulations, and/or policy is undertaken, the organized Medical Staff must first communicate the adoption or amendment to the Medical Executive Committee (MEC), who will have 90 days from date of receipt to review the adoption or amendment, and – if in agreement – propose said adoption or amendment to the governing body.
  - c. If within 90 days of receipt the MEC is not in agreement with said adoption or amendment to rules and regulations and/or policy, the matter shall be subjected to the conflict resolution process noted herein.
  - d. If after 90 days, the Medical Executive Committee has neither agreed nor disagreed on the adoption or amendment to the rules and regulations, and/or policy, the organized Medical Staff may proceed to propose said adoption or amendment directly to the governing body.

**ARTICLE XX: ADOPTION**

The foregoing Amended and Restated Medical Staff Bylaws were approved by the Governing Board on March 15, 2013.

The Title was changed on January 10, 2014.

Further amendments were made by consent of the Active Medical staff in July/August 2015, and approved by the Governing Board on August 20, 2015.

Further amendments were made by vote of the Active Medical Staff in the April 26, 2016 General Medical Staff meeting and approved by the Governing Board on June 16, 2016.

Affirm:

\_\_\_\_\_  
President of the Medical Staff

\_\_\_\_\_  
Secretary of the Medical Staff

Date: \_\_\_\_\_

Date: \_\_\_\_\_



TRINITY MOTHER FRANCES

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MOTHER FRANCES HOSPITAL

# MOTHER FRANCES HOSPITAL RULES AND REGULATIONS

GOVERNING BOARD APPROVAL MARCH 15, 2013

TITLE CHANGE JANUARY 10, 2014

Proposed changes drafted August 2014

Reviewed and Approved August 20, 2015

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## **RULES AND REGULATIONS**

### **A. ADMISSION AND DISCHARGE OF PATIENTS**

1. The Hospital shall accept patients for care and treatment.
2. A patient may only be admitted to the Hospital as an Inpatient or placed in Observation by a member of the Active or Courtesy Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.
3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.
4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.
5. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall when possible first contact the Admitting Department to ascertain whether there is an available bed.
6. Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the Hospital that such said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
7. A patient who is admitted on an emergency basis may select any consenting practitioner in the applicable department or service/section to attend to him. Where no such selection is made, the member of the Active or Courtesy Staff on call in the department or service will be assigned to the patient, on a rotation basis, where possible. The chairman of each department and/or service/section shall provide a schedule for such assignments.
8. Trinity Mother Frances Admissions will admit patients on the basis of the following orders of priorities and placement determined by Bed Control:

- a. Emergency Admissions

Within 24 hours following an emergency admission, the attending practitioner shall document the need for this admission on patient's medical records. History and Physical shall suffice. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.

b. Pre-Operative Admissions

This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Department Chief of Surgery may decide the urgency of any specific admission.

c. Routine Admissions

Shall be accepted from an Active or Courtesy Category Medical Staff member. Reservations shall be accepted in Bed Control and must be received by facsimile, telephone, or hand-delivered information. Orders for admission shall be received in Bed Control prior to admission or at the time of the patient's arrival.

d. Day Surgery patients must be admitted at least two (2) hours prior to their surgical procedure.

9. Areas of restricted bed utilization and assignment of patients shall be in accordance with approved recommendations of the Hospital Practice Improvement Committee and specified in Hospital policy. It is understood that when deviations are made from assigned areas as indicated above, Bed Control will correct these assignments at the earliest possible moment, in keeping with transfer priorities.

10. Patient Transfers. Transfer priorities shall be as follows in the following priority:

- a. Emergency Care Center to appropriate patient bed;
- b. From Obstetrical patient care area to general care area, when medically indicated;
- c. From Critical Care Department to general care area;
- d. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

No patient will be transferred without such transfer being approved by the responsible practitioner.

11. The admitting practitioner shall be expected to give such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

12. For the protection of patients, the Medical and Nursing staffs, and the Hospital, certain principles are to be met in the care of the potentially suicidal patient:

- a. Patients admitted for suicidal intent or overdose to the Intensive Care Unit area must have their suicidal status evaluated at time of transfer from the unit.

- (1) If patient remains suicidal or has suicidal inclinations, the patient should be transferred to an appropriate facility. The patient may be transferred to a Mother Frances Hospital Nursing Unit if a qualified Hospital staff member is in constant attendance.
- (2) If the patient is not suicidal or does not demonstrate suicidal inclinations, the patient may be transferred to an appropriate facility or routine nursing unit.

### 13. Admissions to Intensive Care Unit

The criteria for admission to the Intensive Care Unit shall be based on the severity of illness and intensity of service and the likelihood of benefit from receiving ICU level care. Severity of illness relates to the patient's abnormal physiology whereas the intensity of service relates to the use of monitoring, the degree of critical care technology being applied, the medications being used and to the intensity of bedside nursing care that must be administered.

Patients admitted to the ICU by a cardiologist must consult an intensivist if the patient's ICU stay exceeds forty-eight (48) hours. Patient orders must be available at time of admission. Physicians must provide patient orders by telephone or facsimile.

If any question as to the validity of admission to or discharge from the Critical Care Department should arise, that decision is to be made through consultation with the Medical Director of the ICU. A specialist must be consulted in all complicated situations where the specific skills of other practitioners may be needed. All urgent or stat consults are to be Physician to Physician requests. Stat or urgent consults shall be documented in the progress notes.

The Attending Physician or consulting physician responsible for the care of the patient in the ICU response times for Critical Care admissions and transfers are as follows:

Unstable Patients – Response time is within 60 minutes of admission or transfer to the ICU. Examples of unstable patient: shock of any etiology that has not responded to initial therapy or ventilated patients that are difficult to oxygenate or ventilate.

Stable Patients – Response time is within six (6) hours of admission or transfer to the ICU.

Attending physicians may delegate initial ICU assessment to an Advanced Allied Health Practitioner. Advanced Allied Health Practitioners are responsible for reviewing the case with the Attending Physician immediately following their initial assessment.

If the patient remains unstable or becomes unstable after being initially evaluated by the Advanced Allied Health Practitioner, then it is the responsibility of the Attending Physician to do a bedside assessment within 60 minutes of initial admission or transfer to the ICU or obtain consultation with an intensivist.

14. Patient/Discharge

Patients shall be discharged only on a written order of a member of the Active Medical Staff.

- a. Should a patient leave the Hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record.

15. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. Suicides, known or suspected and accidental deaths, shall be reported to the local law enforcement authorities. Policies with respect to release of dead bodies shall conform to local law.

16. It shall be the duty of all staff members to secure autopsies whenever possible in keeping with Policy D.76. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies performed in the Hospital shall be performed by a Pathologist on the Medical Staff. Provisional anatomic diagnoses shall be recorded on the medical record within a reasonable time. The complete autopsy report should be made a part of the record within 30 days.

17. The use of restraints shall be limited to only those situations in which alternatives have failed or there is imminent danger to self or others. Any use of restraints requires appropriate clinical justification. A written time limited order is necessary from the physician for each use of restraints. PRN orders shall not be accepted. (Refer to Policy D-117 approved by the Medical Staff).

**B. MEDICAL RECORDS DOCUMENTATION**

1. **Attending Physician Responsible.** The attending practitioner is the physician of record and is responsible, within the scope of his/her license and privileges, for the professional quality care and treatment of each patient s/he admits and cares for, holds legal and ethical responsibility for directing care of the patient and ensures the patient's documented visit accurately reflects the care rendered, clinical outcomes and treatment plans.

2. **History and Physical Exams.** A complete history and physical (H&P) exam has the following components: history, physical examination, assessment and treatment plan as indicated:

- a. History and Physical Exams. A complete H&P has the following components: history, physical examination, assessment and treatment plan as indicated:

- i. History includes:

- Presenting diagnosis/condition (chief complaint/reason for the visit)
- Description of symptoms
- Current medications, biological, nutraceuticals
- Any drug allergies

- Significant past medical & surgical history
- Review of systems
- Psychosocial status
- Nutritional evaluation (if GI, pediatrics, or elderly)

For surgery or invasive procedure requiring moderate sedation or anesthesia:

- Indications
- Proposed procedures
- ASA Classification: regardless of whether Anesthesiology is providing care
- Immunizations (pediatric patients only)
- Neonatal history (pediatric patients, if applicable)

b. Physical examination (should include as appropriate an examination of body areas/organ systems):

- Vital Signs
- Cardiovascular system
- Respiratory system
- Neurological system
- Gastrointestinal system
- Eye
- Ear, nose and throat (ENT)
- Genitourinary system
- Musculoskeletal
- Skin
- Psychiatric
- Hematologic/lymphatic/immunologic

c. Assessment

d. Treatment Plan

3. **Interval H&P.** The interval H&P must reference the previously performed complete H&P and must contain documentation of the changes in medical history or physical exam, or a statement indicating that no changes have occurred. The interval H&P must provide sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status since the original complete H&P.

4. **Focused H&P.** The focused H&P is a brief account of the patient's condition and must provide sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status. It should include:

- History of present illness (including chief complaint)
- Current medications, biological, nutraceuticals
- Relevant past medical and surgical history
- Family history
- Relevant review of systems
- Indications and proposed procedures for any surgery or invasive procedure
- Physical examination as indicated
- Assessment
- Treatment Plan

NOTE: Focused H&P is referenced in the use of Sedation and Anesthesia.

5. **Daily Care of Patients/ Progress Note.** A hospitalized patient must be seen by the Attending Physician or a member of the house staff, or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented on each patient on the day of visit in sufficient detail to allow formulation of a reasonable picture of the patient's clinical stats at the time of observation.

6. **Operative Care of Patients.** Either a full operative or procedure report, or a brief operative or procedure note must be documented immediately following surgery or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred to the next level of care.

The brief operative or procedure note must include the following elements:

- The name of the primary surgeon and assistants
- Postoperative diagnosis
- Procedure performed
- Estimated blood loss or indicate "note", if there was no blood loss
- Complications or indicate "note", if there were no complications.

A full operative or procedure report must be documented or dictated for transcription within 24 hours after surgery. The report should contain:

- Preop diagnosis
- Postop diagnosis
- Operations performed
- Principal surgeon, assistant surgeons, type of anesthesia administered
- Intraoperative findings
- Description of the procedures performed
- Intraoperative complications, if any
- Specimens removed
- Estimated blood loss
- Type of anesthesia or sedation
- Date and time of procedure

7. **Discharge Summary.** The primary purpose of the patient record is for documenting the care of the patient. All patients are required to have a Hospital Discharge Summary (HDS) completed which is accurately crafted to recapitulate the reasons for the hospitalization, describes the significant findings including complications, pertinent events of the patient's hospitalization, procedures performed and treatment rendered; the principal and secondary diagnoses, condition of the patient on discharge; and any specific instructions and orders for follow-up care.

The Hospital Discharge Summary is a "Power Document" which provides

comprehensive and succinct information regarding a patient's hospital course in a uniform format. The Hospital Discharge Summary is the primary communication tool, between the hospital care team, referring physician and all post-hospital providers; the primary document for transitioning care, to enable a subsequent physician or practitioner to reference and understand the patient's medical history; and an important tool to prevent readmissions, improve continuity care and comply with meaningful use and core measure requirements. The HDS is also the primary reference document for coding all clinical services and documentation of quality improvement activities and is a signed legal document to be used for legal purposes, patient care, referrals, performance and quality metrics.

The Joint Commission mandates six components to be included in the Hospital Discharge Summary. (Standard IM.6.10, EP7)

- Reason for Hospitalization – chief complaint and/or history of present illness.
- Significant findings – Final and primary diagnoses.
- Procedures and Treatment provided – Hospital course and/or hospital consults and/or procedures.
- Patient's discharge condition – Documented sense of the patients' condition at discharge.
- Patient and family instructions - discharge medications, activity orders and/or therapy orders, dietary instructions and plans for medical follow-up.
- Attending physician's signature - signature of the Attending Physician, date and time on the discharge summary.

#### Documentation Standardization

**Required Components of the Hospital Discharge Summary.** The format and content should be consistent with the rest of the medical record to include:

- Patient name and demographics
- Admitting and Discharge dates
- Providers
  - Attending, Consultants, Referring and Primary Care Physicians
- Reason for Hospitalization
  - Primary / Final Diagnosis
  - Secondary diagnoses
  - Co-morbidities recorded in diagnostic terms
  - ICD-10 Mindset
- Procedures performed
  - Listing of all procedures performed with results, treatment rendered and complications (if any).
- Update Problem List
  - Formal utilization to identify "New and Chronic" pertinent Problems
  - Update resolved Problems
- Hospital Course – Succinct description
  - Brief pertinent history warranting hospitalization
  - Diagnostic plan developed based on symptoms and working diagnosis
  - Treatment / Interventional plan with significant findings and results
  - Consulting services
  - Pending results and follow up care
- Final physical exam, vital signs and DC weight

- Patient Status – Condition of patient, response to care and prognosis
- Discharge Disposition
  - Accurate Medication List
  - Follow-up plan
  - Specific instructions given to patient and/or family
  - Diet and activity recommendations
  - Rehabilitation potential and plan
- Post-Hospital Plan
- Secure follow-up appointments and referrals prior to discharge.
- Reporting
  - Copies of HDS forwarded to Attending, Referring, Consultants and Primary Physician

The Attending Physician (e.g. the physician who is the designated “*attending*” during the current hospital stay is responsible) is responsible for:

- (i) Completing the Hospital Discharge Summary; or
- (ii) Arranging for another physician to complete the Hospital Discharge Summary

Any delinquency in the timely completion of the discharge summary is the responsibility of the Attending Physician.

**Entries at conclusion of hospitalization.** All diagnoses, co-morbidities, complications, and procedures must be recorded in full at the time of discharge, without the use of symbols or abbreviations, and must be dated and signed by the Attending Physician. The Attending Physician has the responsibility for the accuracy of this information.

The following definitions are applicable to the terms used herein:

- *Principal Diagnosis*: The condition established as the principal or final diagnosis, to be chiefly responsible for causing the admission of the patient to the Hospital for care.
- *Secondary Diagnosis* (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending provider(s) considers significant factor affecting patient’s condition and response to therapy.
- *Comorbidities*: A complicating condition that coexisted at admission with a specific principal diagnosis developed and/or worsened through the hospitalization and is thought to increase the length of stay.
- *Complications* (if applicable): An additional diagnosis that describes a condition arising after the beginning of Hospital observation and treatment and modifying the course of the patient’s illness or the medical care required, and is thought to increase the length of stay.
- *Principal Procedure* (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
- *Additional Procedures* (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.

**Approval Process.** All custom Hospital Discharge Summary Templates developed by different specialties and service lines must have the required components designated in these Bylaws for this document. All Hospital Discharge Summary templates require prior approval from the Med Exec Committee.

A discharge clinical summary shall be completed on all medical records of patients hospitalized over 48 hours except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Executive Committee of the Medical Staff, and for these, a final summation-type progress note shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner and shall include instructions for post-hospital care.  
**Discharge summary is the responsibility of the Attending Physician.**

8. **Death Summary** The Death Summary is entered in the electronic health record or dictated for transcription and the content of the death summary should be consistent with the rest of the record and include:
  - Admitting date and reason for hospitalization
  - Date of Death
  - Final Diagnoses
  - Succinct summary of significant findings, treatment provided and patient outcome
  - Goals of Care – if patient was placed on DNR/palliative/comfort/hospice care status
  - Documentation of all procedures performed during current hospitalization and complications (if any)
  
9. **Copy Forward.** Clinical information should never be “cut and pasted” from different patient charts. When specific elements of the same patient’s prior notes do not change from one encounter to the next during the same clinical episode, those elements may be copied forward or preferably acknowledged by reference rather than re-entered. Examples of information that is less controversially copied or carried forward by reference – when truly needed to communicate decision-making for the active encounter – include elements of the previously recorded:
  - Past Medical/Surgical/Obstetric/Psychiatric History
  - Family History
  - Social History
  - Past relevant reports (labs, imaging, pathology, etc.) with dates
  - Some unique circumstances where other aspects of the patient’s history might be copied, such as when the patient is unable to provide this information and the original source (typically a family member or guardian) is no longer accessible.

A patient note must always reflect the status of the patient at the time of note creation. It is inappropriate to Copy Forward elements of the History of Present Illness, Physical Examination, and Assessment and Plan without modifying these

elements to reflect current status of the information, including specific notation of Assessment and Plan that pertains to the current condition of the patient.

In addition, the History of Present Illness, Physical Examination, and Assessment and Plan should reflect the work product of the final author and **not** be carried forward from other providers' notes except in the unique circumstances noted above, and then only with attribution to the original author.

10. **Problem List Utilization.** The problem list should be continuously updated to reflect the medical conditions being treated in the acute care hospital stay, to the greatest degree of specificity possible. It is the responsibility of each provider seeing the patient to address the problem list, but the overall responsibility resides with the Attending Physician. Consultants should add medical problems being addressed by their consultation.
11. **Informed Consent.** It shall be the responsibility of the physician to document that he has provided the patient with the risks, benefits, and alternatives in medical, surgical and anesthesia procedures requiring informed consent. This entry must also be dated and timed. This may be documented in the Physician Progress Notes, in the Operative Report or on the Physician Pre-Sedation Assessment History & Physical or by signing the Anesthesia, Surgical & Medical Informed Consent signed by the patient.
12. **Do Not Resuscitate.** It is the responsibility of the physician writing a "Do Not Resuscitate" order to document in the Progress Notes that the patient or patient's surrogate was involved in the decision.
13. **Consults.** Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations, be verified on the record, and be recorded prior to the operation. Consultations are to be completed within twenty-four (24) hours of the time of request, except as set forth in the applicable ICU or NICU admission policy of the Medical Staff.
14. **Prenatal Record Requirement.** The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
15. **Legibility, Date, Time, Authentication.** All clinical entries in the patient's medical record shall be legible, accurately dated, timed and authenticated in either written or electronic form by the author.
16. **No Unapproved Symbols or Abbreviations.** Designated unapproved symbols and abbreviations should not be used. An official record of unapproved abbreviations should be kept on file in the record room. The use of Unacceptable/Do Not Use Dangerous Abbreviations shall result in clarification with

the practitioner in the interest of patient safety. The use of Unacceptable/Do Not Use Abbreviations applies to all orders and all medication-related documents.

17. **Final Diagnosis**. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.
18. **Patient Consent for Release of Records**. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
19. **American Joint Cancer Committee Staging Form**. The medical record contains the American Joint Cancer Committee staging form and the managing or treating physician must assign the TNM elements and stage group and sign or initial the staging form.
20. **Record Safekeeping**. Original hard copy records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or state law. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.
21. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the IRB and Governing Board. Subject to the discretion of the Administrator or his designee, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
22. All medical records shall be maintained in accordance with the Record Retention and Destruction Policy of the respective facility.
23. A practitioner's preprinted order, when applicable to a given patient, shall be reproduced in detail in the patient's record, dated and signed by the practitioner prior to institution of the order unless delay in physician authorization may cause harm to the patient.
24. All orders (except verbal orders as set forth below) must be dated, timed and authenticated by the next time the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the Medical Staff and granted privileges which are consistent with the written orders, provides care to the patient, assesses the patient, or documents information in the patient's medical record.
25. All verbal orders must be dated, timed and authenticated within forty-eight (48) hours by the prescriber or another practitioner who is responsible for the care of the patient.

26. Medical records shall be completed within **fourteen (14) calendar days** following discharge.
- a. In order to manage the record completion process, The Health Information Management Department will send a notification letter once monthly advising practitioners of the need to complete all delinquent records within 14 days of receipt of the notification.
  - b. Failure to complete records within the designated time frame will result in temporary suspension of admitting and/or clinical privileges until such time as all delinquent records are completed.
  - c. Suspension letter informs the physician in writing that the attached summary medical records report must be completed by a specific date and time; and if the medical records remain incomplete that his/her admitting and/or clinical privileges shall be denied until all delinquent medical records have been completed. This is inclusive of physician signatures / electronic signatures on transcription.
  - d. Suspension letters for failure to complete medical records will be included in the provider's credentialing file and tracked in the OPPE database.
  - e. Physicians may access the electronic medical record system to obtain detailed information regarding their incomplete and delinquent medical records at any time.
  - f. When a private patient of the suspended physician desires admission to this Hospital, the patient shall name another physician of his choice or otherwise be admitted to the applicable Department of the physician on emergency call.
  - g. Three such suspensions of admitting and clinical privileges within any 12-month period may be sufficient cause for referral to the Medical Executive Committee for action.
  - h. Medical Executive Committee may take such action as necessary up to and including recommendation of termination, additional CMEs, and other appropriate actions against any physician with three suspensions within any 12-month period.

**C. GENERAL CONDUCT OF CARE**

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has been refused by the patient. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is admitted to the Hospital.
2. The Medical Staff shall recognize the rights of patients to self-determination including:

- a. The right to accept or refuse medical or surgical treatment;
  - b. The right to formulate advance directives such as through the appointment of an agent to make decisions on his/her behalf (Medical Power of Attorney) or the physician written instructions about health care (Directive to Physicians which includes the Out-of-Hospital DNR).
3. In situations wherein the physician and family or patient disagree on resuscitative measures, the physician, utilizing sound medical judgment, will counsel with the family and patient, document the conversation thoroughly in the medical record and will then respect the patient and/or family's wishes for that care. (See Patient Self-Determination Policy, A – 24)
- a. If an Attending Physician disagrees with and refuses to honor a treatment decision chosen by a patient or the patient's representative, the conflict shall be reviewed by the Ethics Committee. The patient shall be given life-sustaining treatment at a minimum through the review process. The Attending Physician shall not be a member of that committee.
  - b. If the physician, patient or the patient's representative responsible for the healthcare decisions of the patient is requesting life-sustaining treatment that the Ethics Committee decides is inappropriate, the patient shall be given life-sustaining treatment pending transfer. The physician and the facility will work together to transfer the patient to a willing provider.
  - c. If within ten (10) days a willing provider cannot be found life-sustaining treatment may be stopped unless a court of law has granted an extension of time within which life-sustaining treatment must be given. (See Ethics Committee Policy, A-23).
4. All orders for treatment shall be in writing or electronically submitted and must comply with current Hospital policy for telephone orders.
5. The practitioner's orders must be written clearly, legibly and completely and dated and timed. Orders which are illegible or improperly written will not be carried out until rewritten and understood by the nurse.
6. All previous orders are reconciled when patients go to surgery or the ICU.
7. All drugs and medications administered shall be those approved by the Food and Drug Administration. Drugs for approved clinical investigations may be exceptions. Investigational drug protocols will be approved by the Investigational Review Board (IRB). These shall be conducted in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Food and Drug Administration.
8. Any medication which the patient brings with him for continued use in the Hospital should be duly recorded by the physician, or nurse and placed in the custody of the charge nurse.

9. Medication shall be administered to patients only by registered nurses or licensed vocational nurses properly oriented and according to Nursing Service policies and procedures; or by physicians; or Advanced Allied Health Practitioners with prescriptive authority by the following licensed persons: respiratory therapists; radiology technicians; nuclear medication technicians; physical therapists; pharmacists, when done so within the scope of their responsibilities and consistent with laws and regulations, and policies of their department. All such administrations of medication shall be pursuant to the order of a prescriber with clinical privileges granted by the Medical Staff. The pharmacist shall dispense medication only for use under such circumstances.
10. Generically equivalent drugs will be administered by the Pharmacy.
11. Any qualified practitioner with clinical privileges in this Hospital may be called for consultation within his area of expertise. If usual methods of obtaining a consult are unsuccessful and the Attending Physician believes patient care will be compromised without appropriate consultation, the Section Chief, Department Chairman, President or President-Elect of the Medical Staff may require a consultation based on the appropriate unassigned Emergency Department call schedule. Such a required consultation will be mandatory and performed in an expeditious manner by the on-call member of the Medical Staff.
12. Consultation is encouraged in the following situations:
  - a. When the patient is not a good risk for operation or treatment;
  - c. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
  - c. Where there is doubt as to the choice of therapeutic measures to be utilized;
  - d. In unusually complicated situations where specific skills of other practitioners may be needed;
  - e. In instances in which the patient exhibits severe psychiatric symptoms;  
and
  - f. When requested by the patient or his family.
13. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. All consultations should be made physician to physician or with knowledge and consent of the sponsoring physician.
14. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained she/he shall call this to the attention of his/her supervisor who in turn may refer the matter to the Clinical Director, Clinical Coordinator, Chief Nursing Officer and/or Medical Director. If warranted, the Chief Nursing Officer or her designee may bring the matter to the attention of the chairman of the department and/or section chief wherein the practitioner has clinical privileges. Where circumstances are such as

to justify such action, the chairman of the department and/or section may himself request a consultation.

15. All Allied Health Professional personnel who are either in the employ of a private Medical Staff Member or whom he brings in for either teaching or assisting purposes are the direct responsibility of that individual physician. Failure by the Allied Health Practitioner to comply with Bylaws, Regulations, or Hospital policy may result in the suspension of Allied Health Practitioner supervision privileges for the Medical Staff Member. Advanced Allied Health Professional Personnel shall be credentialed according to the medical staff process. Dependent Allied Health Professional Personnel shall be credentialed according to Allied Health Professionals Manual, Section 1.7-7.
16. All clinical laboratory procedures ordered by the physician shall be performed in the Hospital laboratory if such procedures are available. Laboratory procedures not available in the Hospital laboratory may be referred only to laboratories recommended by the Chief of the Pathology Section and approved by the Medical Executive Committee.
17. Diagnostic and therapeutic radiology services shall be maintained and directed by one or more qualified radiologists. Performance and interpretation of radiological examinations shall be made by a qualified radiologist whose name shall be specified in the written order for the examination by the referring physician. Privileges to perform specific limited interpretative diagnostic and monitoring radiologic studies which have been granted to staff physicians who are not radiologists should be of a highly specialized nature, the performance of which requires special qualifications or training and/or experience in the use of the equipment and in the interpretation of results, as well as practice in a field of related diagnostic/therapeutic activities. Credentials files of all physicians thus engaged shall reflect the training, experience and current competence required for the aspects of radiological services for which they are engaged. All off-site therapeutic radiology shall be referred to an appropriately accredited facility that has been recommended by the Department Chairman and approved by the Governing Board when not available in-house.
18. Laboratory, x-ray and other reports of diagnostic procedures performed outside the Hospital but related to a patient's current admission shall be placed on the patient's record to substantiate the diagnoses and treatment.
19. The legal code of the State of Texas, regulating adoptions and child placements, shall be observed and enforced at all times.
20. In the interest of patient safety critical lab values called to the physician shall be read back so as to confirm accurate transmittal to the physician.
21. Medication reconciliation is a prescribing activity and as such the execution of medication reconciliation is seen as a responsibility of the physician. Medication reconciliation shall be completed on admission, at the time of patient transfer to a different level of care and at the time of the patient's discharge.

22. To facilitate the care of the patient, timely care is required and all patients admitted through the Emergency Department shall be seen by the Attending Physician of record no later than 12:00 Noon on the day following their admission. Orders written by the Emergency Department physician shall expire at the time the patient is seen by the Attending Physician of record, or no later than 12:00 Noon the day following their admission. The Attending Physician shall be notified via telephone at 7:00AM and reminded of the patient's admission and expiration of orders at 12:00 Noon. Patients shall be seen daily by the Attending Physician or consultant who may have assumed care of the patient.
23. All patients admitted to the Hospital or placed in observation will be evaluated by a member of the Active or Courtesy Medical Staff. Allied Health Practitioners may not independently admit patients.

**D. GENERAL RULES REGARDING SURGICAL CARE**

1. Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or an unconscious patient in which consent for surgery cannot be immediately obtained from patients, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. It shall be the physician's obligation to have the required informed consent form completed prior to surgery or any other medical procedure requiring consent.
2. In keeping with the requirements of the Texas Medical and Disclosure Panel it shall be the responsibility of the physician to document that he has provided the patient with the risks, benefits, and alternatives in medical and surgical procedures requiring informed consent. The date and time informed consent is given must also be documented by the physician pre-procedure.
3. Except in severe emergencies, the preoperative diagnosis and pertinent laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. In elective surgery the history and physical must be completed and on the medical record prior to surgery.
4. All patients shall be assessed preoperatively according to Medical Staff approved policies. This assessment shall be documented by the practitioner prior to conducting emergent and non-emergency operative and other procedures.
5. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and physician member of the Medical Staff.
  - a. Dentists' or Podiatrists' responsibilities:
    - (1) A detailed dental or podiatric history justifying Hospital admission;
    - (2) A detailed description of the examination of the oral cavity or

podiatric issue and a preoperative diagnosis;

- (3) A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed;
- (4) Progress Notes as are pertinent to the oral or podiatric condition;
- (5) Clinical resumé (or summary statement);
- (6) Pertinent instructions to patient and/or family at time of discharge.

b. Physicians' responsibilities:

- (1) Medical history pertinent to the patient's general health;
- (2) A physical examination to determine the patient's condition prior to anesthesia and surgery;
- (3) Supervision of the patient's general health status while hospitalized.

c. The discharge of the patient shall be on written order of the dental or podiatric member of the medical staff and he will be responsible for post-operative instructions.

d. Patients admitted to the Hospital for oral maxillofacial/dental surgery and/or podiatric care shall receive the same basic medical appraisal as patients admitted for other services, whether the appraisals are performed by a physician member of the medical staff or an Oral and Maxillofacial Surgeon qualified to complete an admission history and physical examination and assess medical risks of the procedure to the patient. A physician member of the medical staff shall be responsible for the care of medical problems that may be present upon admission or that may arise during hospitalization of the Oral Surgery patient.

e. Patients admitted for Podiatric care shall receive the same basic medical appraisal as patients admitted for other services. A qualified practitioner shall be responsible to complete the history and physical exam and assess the medical risks concerning the procedure as it pertains to the patient prior to surgical intervention. The Podiatrist shall be responsible for the portion of the history and physical examination related to Podiatry prior to surgical intervention.

f. When Podiatric surgery is being done under general anesthesia, an Anesthesiologist will be responsible for the anesthesia and for any resuscitative efforts should they be needed.

6. The Anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, or pre-sedation evaluation immediately prior to induction or moderate deep sedation/analgesia and post-anesthetic or

post-sedation/analgesia follow-up of the patient's condition. Post-anesthesia assessment, to be done within forty-eight hours of discontinuation of anesthesia and prior to discharge from the Hospital, include: 1) respiratory function including respiratory rate, airway patency, and oxygen saturation, 2) cardiovascular function including heart rate and blood pressure, 3) mental status, 4) temperature, 5) pain, 6) nausea and vomiting, and 7) postoperative hydration.

7. All tissues removed at operation, with the exception of those exempted by the Pathologist and Medical Staff shall be sent to the "selected" Pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.
8. Surgeons must be in the operating room and ready to commence operation at the time scheduled and in no case will the operating room be held longer than fifteen minutes after the time scheduled.
9. Planning, marking and making a surgical incision or administering a pain block is the responsibility of physicians who have been involved in a formal surgical or anesthesia training and who hold surgical or anesthesia privileges for the specific procedure being performed. Non-physician providers privileged to do so may perform a subsequent incision when directly supervised by the surgeon.
10. All general Dentists and Podiatrists will have a physician Anesthesiologist in attendance for all anesthesia administered in the Hospital and Outpatient Services.

#### **E. GENERAL RULE REGARDING PROHIBITION OF CONTRACEPTIVE STERILIZATION**

Contraceptive sterilization is prohibited. All cases involving a procedure that induces sterility for non-pathologic reasons as an unintended but foreseeable secondary outcome must be referred to the Ethics Committee.

#### **F. EMERGENCY SERVICES**

1. Emergency room services, other than those provided by the Emergency Department Physician, shall be provided by the physician on call on a rotation basis. Patients who are admitted to the Hospital on an emergency basis and who do not have an Attending Physician may request any consenting practitioner without obligation in the applicable department or section as determined by the Emergency Department Attending Physician. Where no such selection is made, the member of the Active Category Staff or Courtesy Category Staff, Locum Tenens division on call in the department or section will be assigned to the patient. Physicians on call must be able to physically respond in person to the Emergency Department within thirty (30) minutes. The chairman of each department and/or section or his designee shall provide a schedule for such assignments. Each Medical Staff department/section shall formally define the age members of their specific department/section are eligible to be relieved of their on call responsibility. When there are insufficient Active Category physicians in a department or section to provide full call coverage, each physician in the department or section shall assume a reasonable response obligation at the discretion of the Medical Executive Committee.

2. An appropriate medical screening within the capability of the emergency department, including ancillary services routinely available to the emergency department, shall be provided to all individuals who come to the emergency department seeking care or if a prudent layperson observer would conclude from the individual's appearance or behavior have a need for examination and treatment of a medical condition. This medical screening examination (MSE) will be conducted by a physician or Allied Health Professional who has received training in emergency medical services and can render immediate life-saving treatment. To the extent possible, the physician on duty shall oversee the MSE.

The patient presenting with a private physician on the staff shall be the responsibility of that physician and his/her designee will be notified if requested. The medical staff shall provide an appropriate required medical screening examination consistent with the symptom(s) for individuals presenting in the Emergency Care Center to include all necessary ancillary services routinely available to the ECC before discharge or transfer.

3. The duties and responsibilities of all personnel serving patients within the Emergency area shall be defined in policy and procedure. The contents of such policy and procedure shall be developed by the Department of Emergency Medicine.
4. An Advanced Allied Health Practitioner may not substitute for an Active member of the medical staff in providing call responsibility for the Hospital. If an Advanced Allied Health Practitioner is assisting in the call responsibility of their supervising physician, the Emergency Department Physician has the authority to speak directly with the physician on call and request their presence within 30 minutes.
5. Patients admitted or placed in observation to the Hospital under the care of an Attending Physician should be seen on day of admission and must be seen by noon of the following day unless otherwise directed under Intensive Care Unit admissions.
6. Consultation performed in the Emergency Department at the request of a member of the Medical Staff and assisted by an Advanced Allied Health Practitioner must be seen and evaluated by a Sponsoring Physician prior to discharge home from the Emergency Department
7. The Medical Staff member on-call may not refuse an appropriate transfer of an individual if the Hospital has the specialized capabilities, available personnel and space for appropriately treating the needs of an individual requiring a higher level of care.
8. The Emergency Department Medical Staff or the Medical Staff member on-call shall provide an appropriate medical screening consistent with the symptom(s) when: individuals arrive at the Hospital who may or may not be under the immediate supervision of a personal Attending Physician; has one or more diagnosed or undiagnosed medical conditions; and, within reasonable medical probability, requires immediate or continuing Hospital services and medical care;

or requests medical treatment. This screening shall include ancillary services routinely available to the ECC before transfer.

9. Pregnant women of greater than twenty (20) weeks gestation who present with isolated pregnancy-related complaints shall receive a medical screening by a qualified medical provider in the L&D area.
10. A qualified medical provider for the L&D area is a licensed practitioner with current clinical obstetrical privileges or a registered nurse who has been deemed competent through core and/or annual competencies to provide a nursing assessment and diagnosis of the following in the pregnant patient: true vs. false labor; evaluation of FHTs; observation of the regularity and duration of uterine contractions and status of membranes.
11. If a nurse midwife, clinical nurse specialist or registered nurse performs the medical screening, the patient's status must be discussed with the responsible obstetrician prior to the patient being discharged. The responsible obstetrician must decide whether the findings constitute a medical emergency.
12. If the case is beyond the Advanced Allied Health Practitioner's expertise or scope of practice, the obstetrician shall examine and evaluate the patient to conduct further medical screening. Following Obstetric evaluation, if a non-pregnancy related emergency medical condition is suspected, the patient may be transferred to the ECC after consultation with the Emergency Department Physician or an appropriate consultant shall be called to evaluate and stabilize the patient.
13. The Medical Staff shall inform each patient or the person acting on his/her behalf of the risks and benefits to the individual of examination and treatment and/or transfer and take all reasonable steps to secure the patients written consent to refuse such examination and treatment and/or transfer.
14. The transferring Medical Staff member shall determine and order life support measures which are medically appropriate to stabilize the patient prior to transfer and sustain the patient during transfer. He shall also determine and order the appropriate medical personnel and equipment for the transfer.
15. Prior to each individual transfer the transferring Medical Staff member authorizes the transfer shall personally examine and evaluate the patient to determine the patient's medical needs and to assure that appropriate transfer procedures are utilized unless the time required would unnecessarily delay the transfer to the detriment of the patient.
16. An appropriate medical record shall be kept for every patient receiving emergency service in accordance with current standards of the Joint Commission. This information shall be incorporated in the patient's Hospital record if patient is admitted to the Hospital.
17. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.
18. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other

emergency facilities in the community. The plan shall be approved by the Medical Staff.

## **G. RULES REGARDING ALLIED HEALTH PROFESSIONALS**

1. Rules regarding Allied Health Professionals are found in the Allied Health Professionals Manual.
2. Unless otherwise provided by Hospital policy or scope of practice, the Sponsoring Medical Staff Member shall:
  - (a) Abide by the Bylaws, Rules and Regulations, policies and procedures governing the service of AHPs in this Hospital and utilize the AHP in accordance with the AHP's delineated scope of practice and/or authorized scope of service in the Hospital;
  - (b) Be specifically privileged by the Credentials Committee to supervise AHPs;
  - (c) Accept full responsibility for the proper conduct of the AHP within the Hospital, for the AHP's observance of the Bylaws, Rules and Regulations, policies and procedures of the Hospital and Medical Staff, and for the correction and resolution of any problems that may arise;
  - (d) Maintain ultimate responsibility for directing the course of the patient's medical treatment and provide active and continuous overview of the AHP's activities in the Hospital to ensure that directions and advice are being implemented;
  - (e) Ensure that the AHP maintains the necessary qualifications and competency to provide services as required in these Bylaws;
  - (f) Delegate the performance of any medical acts in accord with applicable law and within the AHP's delineated scope of practice and authorized scope of service; and
  - (g) Notify immediately the Credentials Committee or Medical Staff services office in the event any of the following occurs:
    - i. Termination of an agreement to serve as a Sponsoring Medical Staff Member or employment of the AHP;
    - ii. The Sponsoring Medical Staff Member's approval to supervise the AHP is revoked, limited, or otherwise altered by action of the applicable state licensing board; or
    - iii. The Sponsoring Medical Staff Member is notified of investigation of the AHP or of the member's supervision of the AHP by the applicable state licensing board or any other accrediting body.
  - (h) Perform ten (10) chart reviews per month, and participate in face-to-face meetings with the collaborated/supervised AHP with the respective date and signature of both parties documented on the logs provided. The logs are to be kept by the AHP.
  - (i) Be available for appropriate supervision of the AHP in accordance with these Bylaws and upon request of AHP.
  - (j) Physicians utilizing AHPs must see their patients within twelve (12) hours of admission and all consultations should be made physician to physician or with knowledge and consent of the sponsoring physician

- (k) Attending physicians may delegate initial ICU assessment to an Advanced Allied Health Practitioner. Advanced Allied Health Practitioners are responsible for reviewing the case with the Attending Physician immediately following their initial assessment.
  - (l) If the patient remains unstable or becomes unstable after being initially evaluated by the Advanced Allied Health Practitioner, then it is the responsibility of the Attending Physician to do a bedside assessment within sixty (60) minutes of initial admission or transfer to the ICU.
- Failure to follow these responsibilities may result in restriction or loss of privileges for AHPs.
  - AHPs may not be a substitute for physician call responsibilities.

#### **H. Rules for Supervision of Residents**

- a. Residents are provided clinical rotations at the Hospital under the supervision of the attending medical staff. The management of each patient's care, treatment and services is the ultimate responsibility of the licensed independent practitioner with appropriate clinical privileges. Residents may not independently diagnose, treat or discharge patients from the Hospital.
- b. The parameters of medical practice and defined process for supervision for the Residents are defined within the Affiliation Agreements and/or the Program Letters of Agreement with the sponsoring educational facility.
- c. PGY1 & PGY2 Residents may enter "Orders" without a co-signature, after consulting with and approval by the Attending Medical Staff. PGY3 & PGY4 Residents are able to enter "Orders" without the need of a co-signature by the Attending Medical Staff. All Resident "Notes" must be co-signed by the Attending Medical Staff.